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July–December, 1945

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- I. Authors.
- II. Subjects—Titles of Papers.
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- IV. California Medical Association.
  - (a) Official Notices, Minutes, Committees.
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### Key to Abbreviations in This Index

Or.—Original Article (Scientific and General).

C.R.—Case Report (Clinical Notes).

Ed.—Editorial.

E.C.—Editorial Comment.

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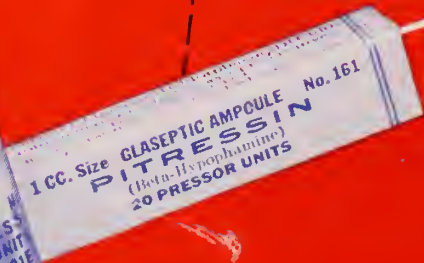
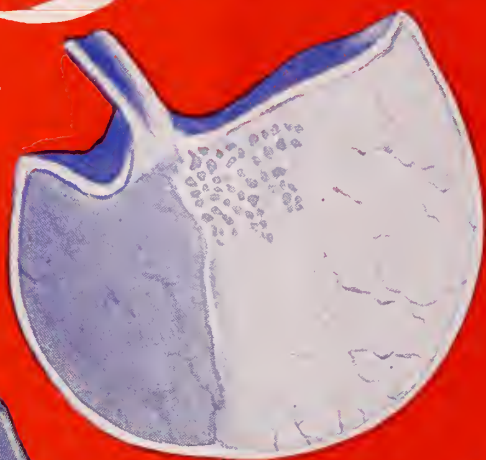
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# Selective

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*for pressor and oxytocic effects*

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*for pressor and antidiuretic effects*

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President-Elect—Sam J. McClendon, 2654 Fourth Avenue, San Diego 3.	Chairman of the Council—Philip K. Gilman, Crest Road, San Anselmo.	Executive Secretary—John Hunton, 450 Sutter Street, Room 2004, San Francisco, 8.
Speaker of House of Delegates—E. Vincent Askey, 2210 West Third Street, Los Angeles 5.	Vice-Chairman—John W. Cline, 490 Post Street, San Francisco, 2.	General Counsel—Hartley F. Peart, Room 1800, 111 Sutter Street, San Francisco 4.

## Councilors

In addition to the elected district and at-large Councilors, the Council has as ex-officio members the following general officers, President; President-Elect; Speaker; and the Association Secretary.  
Council Officers: Philip K. Gilman, Chairman; George H. Kress, Secretary.

District Councilors		
<b>First District</b> —Imperial, Orange, Riverside, San Bernardino and San Diego Counties, Herbert A. Johnston (1947), 117 N. Claudina Street, Anaheim.	<b>Fifth District</b> —Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz Counties, R. Stanley Kneeshaw (1948), 404 Medico-Dental Building, 241 East Santa Clara Street, San Jose.	<b>Ninth District</b> —Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma and Trinity Counties, John W. Green (1946), Box 539, Vallejo.
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<b>Third District</b> —Inyo, Kern, Mono, San Luis Obispo, Santa Barbara and Ventura Counties, Harry E. Henderson (1946), 1421 State Street, Santa Barbara.	<b>Seventh District</b> —Alameda and Contra Costa Counties, Lloyd E. Kindall (1947), 400 Twenty-ninth Street, Oakland.	Walter S. Cherry (1948), 109 N. Riverside Ave., Rialto, San Bernardino County.
<b>Fourth District</b> —Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties, Axel E. Anderson (1947), Medical Group Building, 1759 Fulton Street, Fresno.	<b>Eighth District</b> —Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties, Frank A. MacDonald (1948), 822 Medico-Dental Building, 1127 Eleventh Street, Sacramento 14.	Edwin L. Bruck (1948), 384 Post Street, San Francisco, 8.
		Sidney J. Shipman (1947), 490 Post Street, San Francisco 2.
		E. Earl Moody (1947), 829 South Alvarado Street, Los Angeles.
		Dewey R. Powell (1946), Room 501, 242 North Sutter Street, Stockton 2.
		<b>Edward B. Dewey (1946), Professional Building, 65 North Madison Avenue, Pasadena.</b>

## Standing Committees

Executive Committee			Committee on Publications		
The President, the President-Elect, the Speaker of the House of Delegates, the Chairman of the Council, the Chairman of the Auditing Committee, the Secretary-Treasurer (ex officio), and the Editor (ex officio). John W. Cline, Chairman; George H. Kress, Secretary.			George W. Walker (Chairman).....	Fresno	1946
			F. Burton Jones .....	Vallejo	1947
			R. H. Sundberg.....	San Diego	1948
			Secretary-Editor, ex officio		
Auditing Committee*			Committee on Public Policy and Legislation		
John W. Cline (Chairman).....	San Francisco	1945	Edmund T. Remmen.....	Glendale	1946
Edwin L. Bruck.....	San Francisco	1945	Dwight H. Murray (Chairman).....	Napa	1947
Lloyd E. Kindall.....	Oakland	1945	Lloyd E. Kindall.....	Oakland	1948
Committee on Associated Societies and Technical Groups			Association President .....	ex officio	
John V. Barrow (Chairman).....	Los Angeles	1946	Association President-Elect .....	ex officio	
Anthony B. Diepenbrock.....	San Francisco	1947	Advisory Committee		
Edward F. Nippert.....	Hollywood	1948	Junius B. Harris (Chairman).....	Sacramento	
Committee on Health and Public Instruction			H. R. Madeley (Vice-Chairman).....	Vallejo	
J. C. Geiger (Chairman).....	San Francisco	1946	Wilson Stegeman .....	Santa Rosa	
E. Earl Moody .....	Los Angeles	1947	Committee on Scientific Work		
C. M. Burchfiel.....	San Jose	1948	George H. Kress (Chairman).....	ex officio	
Committee on History and Obituaries			Fletcher B. Taylor.....	Oakland	1946
Hyman Miller .....	Los Angeles	1946	J. Homer Woolsey .....	Woodland	1947
Morton R. Gibbons, Sr. (Chairman).....	San Francisco	1947	Howard F. West.....	Los Angeles	1948
Robert A. Peers.....	Colfax	1948	Francis L. Chamberlain (ex officio, Secretary, Section on Medicine)		
George H. Kress.....	ex officio		Eugene J. Joergenson (ex officio, Secretary, Section on Surgery)		
Committee on Hospitals, Dispensaries and Clinics			Committee on Public Relations		
Benjamin W. Black.....	Oakland	1946	The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio.		
Roy E. Thomas .....	Los Angeles	1947	J. C. Geiger.....Chair, Com. on Health and Public Instruction		
Clarence E. Rees (Chairman).....	San Diego	1948	Clarence E. Rees.....Chair, Com. on Hospitals, Dispensaries, Clinics		
Committee on Industrial Practice			Donald Cass.....Chair, Com. on Industrial Practice		
Carl L. Hoag.....	San Francisco	1946	Nelson J. Howard.....Chair, Com. on Medical Defense		
N. P. Dunne .....	Oakland	1947	Carl L. Mulfinger.....Chair, Com. on Membership and Organization		
Donald Cass (Chairman).....	Los Angeles	1948	H. Gordon MacLean.....Chair, Com. on Medical Economics		
Committee on Medical Defense			Dwight H. Murray, Chair, Com. on Public Policy and Legislation		
Louis J. Regan.....	Los Angeles	1946	F. E. Clough.....Chair, Com. on Postgraduate Activities		
Nelson J. Howard (Chairman) .....	San Francisco	1947	Philip K. Gilman.....President of California Medical Association		
William A. Key.....	San Mateo	1948	Sam J. McClendon.....President-Elect		
Committee on Medical Economics			George H. Kress.....Secretary-Treasurer		
Howard W. Bosworth.....	Los Angeles	1946	Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2004, 450 Sutter Street, San Francisco.		
Wayne J. Pollock.....	Sacramento	1947	Cancer Commission		
H. Gordon MacLean (Chairman).....	Oakland	1948	Lyell C. Kinney (Chairman).....	San Diego	1946
Committee on Medical Education and Medical Institutions			Harold Brunn .....	San Francisco	1946
William J. Kerr.....	San Francisco	1946	Orville N. Meland (Sec'y, Southern Calif.).....	Los Angeles	1946
B. O. Raulston (Chairman).....	Los Angeles	1947	George Sharp .....	Pasadena	1947
L. R. Chandler.....	San Francisco	1948	Whitfield Crane (Vice-Chairman).....	Oakland	1947
Committee on Organization and Membership			Gertrude Moore .....	Oakland	1947
L. H. Redelings.....	San Diego	1946	Henry J. Ullmann.....	Santa Barbara	1948
Carl L. Mulfinger (Chairman) .....	Los Angeles	1947	David A. Wood (Sec'y, No. California).....	San Francisco	1948
Harold G. Trimble .....	Oakland	1948	James F. Rinehart.....	San Francisco	1948
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John C. Ruddock .....	San Diego	1948	Robert A. Peers.....	Colfax	
George H. Kress.....	ex officio				

\* Members appointed each year by the Chairman of the Council.



## OFFICERS OF SCIENTIFIC SECTIONS, CALIFORNIA MEDICAL ASSOCIATION

Members who contemplate presentation of scientific papers should promptly address the secretary of the proper section, as per addresses which follow. Correspondence concerning scientific exhibits, and medical and surgical films, should be addressed to the Chairman of the Committee on Scientific Work: George H. Kress, M.D., 450 Sutter, San Francisco.

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Secretary, Gordon King, Children's Hospital, San Francisco.

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(For roster of County Society officers, see last month's issue.)

## California Physicians' Service

Headquarters office of the California Physicians' Service is located at 153 Kearny St., San Francisco, Postal Zone 8, Telephone EXbrook 0161. Los Angeles office located at 743 South Grand View St., Postal Zone 5, Telephone DRexel 5261.

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(Continued on Page 5)

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# ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

**Alameda County Medical Association**  
364 14th St., Oakland 12  
President, Harry J. Templeton, 3115 Webster Street, Oakland.  
Secretary, Gertrude Moore, 353 30th Street, Oakland, 9.  
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

**Butte-Glenn County Medical Society**  
President, John H. Alexander, 2nd at Main Street, Chico.  
Secretary, J. O. Chiappella, 131 Broadway, Chico.  
Meeting, *Second Thursday.*

**Contra Costa County Medical Society**  
President, Joseph W. Boomer, American Trust Building, Richmond.  
Secretary, Henry W. McNeerney, 2600 McDonald Avenue, Richmond.  
Meeting, *Second Tuesday, 8:00 p. m.*

**Fresno County Medical Society**  
President, John E. Young, Rowell Building, Fresno.  
Secretary, K. D. Luechauer, 1759 Fulton Street, Fresno.  
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

**Humboldt County Medical Society**  
President, Nathan G. Wasserman, 539 G Street, Eureka.  
Secretary, Joseph S. Woolford, 539 G Street, Eureka.  
Meeting, *First Thursday.*

**Imperial County Medical Society**  
President, T. E. Bartholomew, 319 Third Street, Calexico.  
Secretary, Marian Hubbell, El Centro.  
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

**Inyo-Mono County Medical Society**  
President, James Lloyd Mason, Bishop.  
Secretary, Walter L. Wilson, 108 N. Main, Bishop.  
Meeting, *Fourth Wednesday, except December, January, February.*

**Kern County Medical Society**  
President, Sophie L. Goldman, 458 Habersfelde Building, Bakersfield.  
Secretary, Juliet Thorne, 109 Eighteenth Street, Bakersfield.  
Meeting, *Third Thursday, 7:30 p. m., Bakersfield Inn, except June, July, August.*

**Kings County Medical Society**  
President, Lionel W. Sorenson, 1118 Whiteley Avenue, Corcoran.  
Secretary, Arthur Zeisner, 410 N. Irwin Street, Hanford.  
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

**Lassen-Plumas-Modoc County Medical Society**  
President, Fred J. Davis, Jr., 920 Pine Street, Susanville.  
Secretary, J. W. Crever, Susanville.  
Meeting, *On Call.*

**Los Angeles County Medical Association**  
1925 Wilshire Boulevard, Los Angeles 5  
President, J. Jay Crane, 418 South Arden Street, Los Angeles 5.  
Secretary, E. T. Remmen, 429 North Orange, Glendale 3.  
Meeting, *First and Third Thursday, 1925 Wilshire Boulevard, Los Angeles.*

**Marin County Medical Society**  
President, Alex Miller, 1010 B Street, San Rafael.  
Secretary, Carl W. Clark, 1010 B Street, San Rafael.  
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

**Mendocino-Lake County Medical Society**  
Secretary, Dale E. Barber, Fort Bragg.

**Merced County Medical Society**  
President, E. R. Fountain, Merced.  
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.  
Meeting, *Third Thursday, Hotel Tioga, Merced.*

**Monterey County Medical Society**  
President, Edwin Wiley Reeves, 605 Salinas National Bank Building, Salinas.  
Secretary, Dixi M. Bingham, Bank of America Building, Salinas.  
Meeting, *First Thursday.*

**Napa County Medical Society**  
President, Charles H. Bulson, 1203 Seminary Street, Napa.  
Secretary, M. M. Booth, Bruck Building, St. Helena.  
Meeting, *First Wednesday.*

**Orange County Medical Association**  
President, L. F. Whittaker, 302 Third Street, Huntington Beach.  
Secretary, Russell I. Johnson, 181 Seventeenth Street, Westminster.  
Meeting, *First Tuesday, 7:00 p. m., Windsor Cafe, Santa Ana*

**Placer-Nevada-Sierra County Medical Society**  
President, George A. Foster, Grass Valley.  
Secretary, Vernon W. Padgett, Grass Valley.  
Meeting, *At Call of President.*

**Riverside County Medical Society**  
President, Omer W. Wheeler, 1939 La Cadena, Riverside.  
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.  
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

**Sacramento Society for Medical Improvement**  
President, Maurice A. Hopkins, Route 7, Box 1246A, Sacramento.  
Secretary, Edmund E. Simpson, 1127 Eleventh Street, Sacramento 14.  
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

**San Benito County Medical Society**  
President, J. M. O'Donnell, Hollister.  
Secretary, J. J. Haruff, Hollister.  
Meeting, *At Call of President.*

**San Bernardino County Medical Society**  
President, J. J. H. Smith, 137 East H Street, Colton.  
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.  
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

**San Diego County Medical Society**  
President, George D. Huff, 806 Medical Building, San Diego 1.  
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego, 1.  
Meeting, *Second Tuesday, University Club.*

**San Francisco County Medical Society**  
2180 Washington Street 9  
President, G. Dan Delprat, 384 Post Street, San Francisco 8.  
Secretary, Chester L. Cooley, 490 Post Street, San Francisco, 2.  
Meeting, *Second Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco, 9.*

**San Joaquin County Medical Society**  
President, Yale Brody, Bank of America Building, Stockton 5.  
Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton 2.  
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

**San Luis Obispo County Medical Society**  
President, Edward C. Sherman, 784 Marsh Street, San Luis Obispo.  
Secretary, G. D. Kelker, 1114 Marsh Street, San Luis Obispo.  
Meeting, *Fourth Wednesday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

**San Mateo County Medical Society**  
President, Logan Gray, 57 Fourth Avenue, San Mateo.  
Secretary, J. Paul Sweeney, P. O. Box 1004, Millbrae.  
Meeting, *At call of President.*

**Santa Barbara County Medical Society**  
President, George R. Lutton, 103 E. Micheltorena Street, Santa Barbara.  
Secretary, Charles A. Preuss, 1317 Santa Barbara Street, Santa Barbara.  
Meeting, *Second Monday, Cottage Hospital.*

**Santa Clara County Medical Association**  
President, Karl F. Pelkan, 903 Medico Building, San Jose.  
Secretary, Fred W. Borden, Sainte Claire Building, San Jose, 23.

**Santa Cruz County Medical Society**  
President, Anton J. Sambuck, Union Street and Maple Avenue, Watsonville.  
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.  
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

**Shasta-Trinity County Medical Society**  
President, L. C. Mosher, Bieber.  
Secretary, Julius M. Kehoe, Redding.  
Meeting, *Second Monday.*

**Siskiyou County Medical Society**  
President, H. L. Vidricksen, Weed Hospital, Weed.  
Secretary, F. W. Martin, Mt. Shasta.  
Meeting, *Sunday on Call.*

**Solano County Medical Society**  
President, H. Randall Madeley, P. O. Box 539, Vallejo.  
Secretary, John W. Green, Box 539, Vallejo, California.  
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.*

**Sonoma County Medical Society**  
President, William N. Makaroff, Guerneville.  
Secretary, Robert S. Quinn, 3325 Chanate Road, Santa Rosa.  
Meeting, *Second Thursday.*

**Stanislaus County Medical Society**  
President, J. H. Czatt, 810 Fourteenth Street, Modesto.  
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.  
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

**Tehama County Medical Society**  
President, James L. Faulkner, Red Bluff.  
Secretary, R. G. Frey, Red Bluff.  
Meeting, *At Call of President.*

**Tulare County Medical Society**  
President, Charles M. Mathias, 515 Kern Street, Tulare.  
Secretary, James C. Malcolm, 1501 West Main, Visalia.

**Ventura County Medical Society**  
President, Gerald K. Ridge, 704 East Santa Clara Street, Ventura.  
Secretary, George H. Arnold, Route 2, Box 12, Ventura.  
Meeting, *Second Tuesday, Ventura County Country Club.*

**Yolo County Medical Society**  
President, William J. Blevins, Sr., 212 Porter Building, Woodland.  
Secretary, Emery Leivers, Woodland Clinic, Woodland.  
Meeting, *First Wednesday.*

**Yuba-Sutter-Colusa County Medical Society**  
President, Joseph D. Lewis, 725 Fourth Street, Marysville.  
Secretary, Thomas F. Keyes, 725 Fourth Street, Marysville.  
Meeting, *Second Wednesday.*

(For roster of C.M.A. committees and other organization, see last month's issue.)





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### Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 364 Fourteenth Street, Oakland, 12. (Phone Hlgate 7600.) 153 Kearny Street, San Francisco, 8. (Phone GARfield 0813.) 67 East Santa Clara, San Jose.

Hospital Service of Southern California, 743 South Grand View Street, Los Angeles. (Phone DRexel 5261.)

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento. (Main 2548.)

### California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrorse 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WESt 8000, Extension 75.

Barlow Medical Library (Los Angeles County Medical Association), 634 So. Westlake, Los Angeles 5. Phone FItzroy 7694.

Note.—The Library of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, also maintains a medical literature packet service.

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## BOOK REVIEWS

### BOOKS RECEIVED

**Common Ailments of Man.** Edited by Morris Fishbein, M.D., Editor, Hygeia, The Health Magazine. Cloth. Price, \$1.00. Pp. 177. Garden City, New York: Garden City Publishing Co., Inc., 1945.

**A Synopsis of Medicine.** By Sir Henry Letheby Tidy, K.B.E., M.A., M.D., B.Ch. (Oxon.), F.R.C.P. (Lond.); Extra Physician to H.M. The King; Consulting Physician to St. Thomas's Hospital; Hon. Major-General, lately Consulting Physician to the British Army. Eighth Edition, Revised and Enlarged. Cloth. Pp. 1215. Baltimore: The Williams and Wilkins Company, 1945.

**Men Under Stress.** By Roy R. Grinker, Lt. Col., M.C., and John P. Spiegel, Major, M.C., Army Air Forces. Cloth. Pp. 484. Philadelphia: Blakiston, 1945.

**An Index of Differential Diagnosis of Main Symptoms.** By Various Authors. Edited by Herbert French, C.V.O., C.B.E., M.A., M.D. Oxon., F.R.C.P., Consulting Physician, Guy's Hospital; late Physician, H.M. Household. Assisted by Arthur H. Douthwaite, M.D., F.R.C.P., Physician, Guy's Hospital; Honorary Physician, All Saints' Hospital for Genito-urinary Diseases. Sixth Edition. Cloth. Pp. 1128, with Seven Hundred and Ninety-eight Illustrations, of which Two Hundred and Thirty-one are Coloured. Baltimore: The Williams and Wilkins Company, 1945.

(Continued on Page 10)

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#### BOOK REVIEWS

**Clinical Roentgenology of the Digestive Tract.** By Maurice Feldman, M.D., Assistant Professor of Gastroenterology, University of Maryland, Assistant in Gastroenterology, Mercy Hospital, Consulting Roentgenologist, Sinai Hospital. Cloth. Price, \$7.00. Second Edition. Baltimore: The Williams and Wilkins Company, 1945.

This book presents a clinical roentgenological consideration of diseases of the gastrointestinal tract and was written as an aid for the roentgenologic diagnosis of the digestive tract for the roentgenologist, gastroenterologist, student and general practitioner.

The author states he has endeavored to cover every phase of the gastrointestinal tract with the object in view of presenting the importance of the diagnostic value of the roentgen examination.

**Men Under Stress.** By Roy R. Grinker, Lt. Col., M.C., and John P. Spiegel, Major, M.C., Army Air Forces. Cloth. Pp. 484. Philadelphia: Blakiston, 1945.

The stress of war tries men as no other test that they have encountered in civilized life. Like a crucial experiment war exposes the underlying physiological and psychological mechanisms of the human being. Cruel, destructive and wasteful though such an experiment may be, exceedingly valuable lessons can be learned from it regarding the methods by which men adapt themselves to all forms of stress, either in war or in peace.

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(Continued on Page 16)

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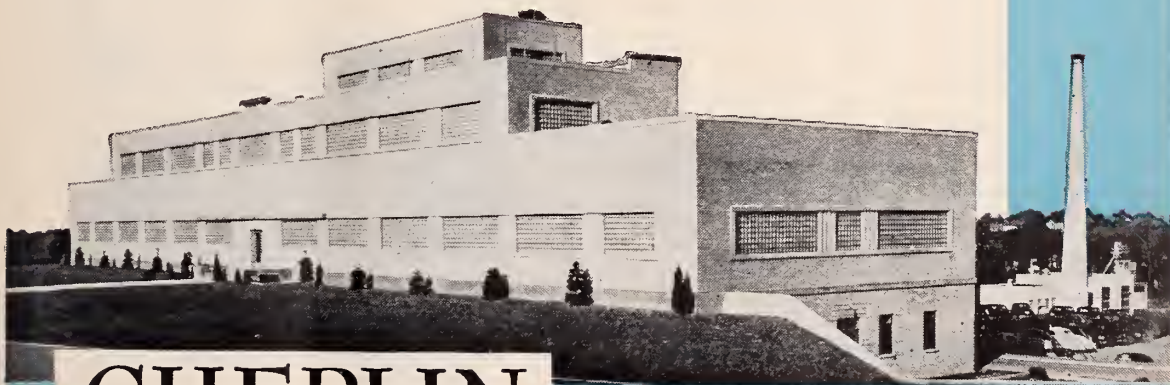


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\*"Bactericidal Efficiency of Iodine Solutions and Organic Mercurial Antiseptics", Amer. Jour. Pharm., 117:5 (Jan.) 1945.

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—Brit. Med. J., No. 4378, pp. 722-723, Dec. 1944.

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—The Lancet, No. 6319, pp. 471-472, Oct. 1944.

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—Hawaii Med. J., No. 5, 3:222-226, May-June 1944.

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### BOOK REVIEWS

(Continued from Page 10)

making successful adaptations.

Because the case material of this book concerns flying personnel almost exclusively, Flight Surgeons will find it useful as a basis of preparation for their psychiatric work. The text material is roughly divided into a discussion of war neuroses appearing overseas and those in combat veterans returned home for relief from flying or for rehabilitation.

**Fundamentals of Pharmacology.** By Clinton H. Thienes, M.D., Ph.D., Professor and Head of the Department of Pharmacology, School of Medicine, University of Southern California, Attending Pathologist (Toxicology), Los Angeles County Hospital. Medical Students Series. Paul B. Hoeber, Inc. Cloth. Price, \$5.75. Pp. 497. New York and London: Harper & Brothers, 1945.

The author of this volume is head of the Department of Pharmacology in the School of Medicine of the University of Southern California.

There was a time when all that was known of medicine and surgery could be put into a single textbook. The first medical school in this country, established about 1765, offered a curriculum of only five subjects: anatomy,

materia medica, chemistry, theory and practice of physic, and a series of "clinical lectures." Today a sizable catalogue is needed to describe all the courses offered students in a modern medical school.

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The author's manual is designed to introduce the student to the subject of pharmacology and to stimulate the practitioner, teacher, and investigator to think in fundamental terms with respect to pharmacology.

The curricula of medical schools in America usually leave the students little time for consulting original sources or other texts. However, students should be encouraged to read as widely as possible and physicians and other readers may desire to consult original articles.

The text of this book is arranged in an order somewhat different from that of most textbooks. Systemically acting drugs are discussed first.

(Continued on Page 17)



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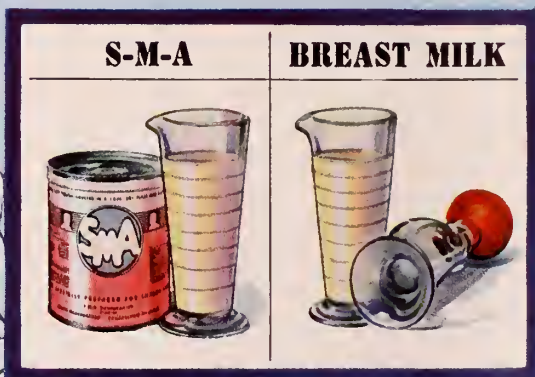
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### BOOK REVIEWS

(Continued from Page 16)

The topics were selected for discussion either because of its importance to the practitioner or because of their value in training the student, as determined by the author's experience.

**Common Ailments of Man.** Edited by Morris Fishbein, M.D., Editor, *Hygeia*, The Health Magazine. Cloth. Price, \$1.00. Pp. 177. Garden City, New York: Garden City Publishing Co., Inc., 1945.

The conditions included in this book are among the most frequent of those which cause people to consult physicians. Many of the conditions are symptoms rather than diseases, as for instance, to headache, constipation and backache. For that very reason the best advice that

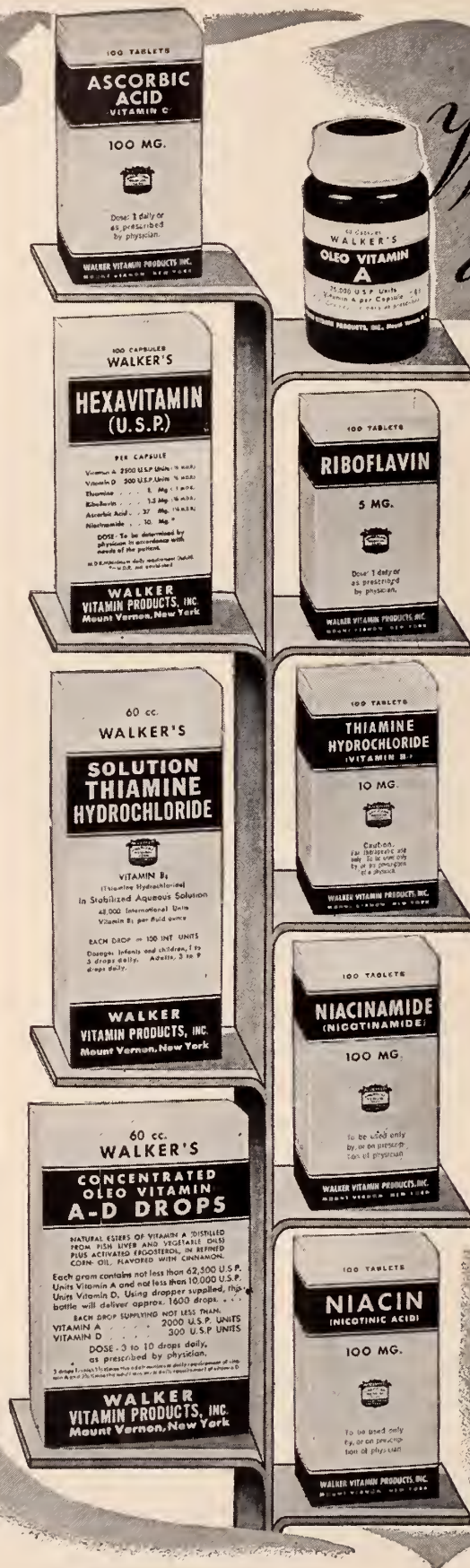
can be given to anyone who has one of these symptoms is to consult a competent doctor and to get a scientific diagnosis and an accurate recommendation as to treatment. Self-treatment is dangerous because it postpones scientific diagnosis. It is dangerous because it does not permit the prescription of the best possible remedy for the individual concerned in the amount necessary for his case.

With these considerations in mind, people may nevertheless know with advantage many of the main facts about the conditions that trouble them.

**Arterial Hypertension.** Its Diagnosis and Treatment. By Irvine H. Page, M.D., and Arthur Curtis Corcoran, M.D., Research Division of the Cleveland Clinic Foundation, Cleveland; formerly Lilly Laboratory for Clinical

(Continued on Page 20)

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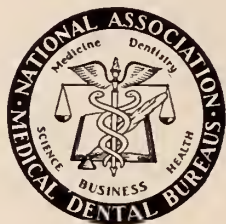
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### BOOK REVIEWS

(Continued from Page 17)

Research, Indianapolis City Hospital, Indianapolis. Cloth. Price, \$3.75. Pp. 352. Chicago: The Year Book Publishers, Inc., 1945.

This volume is intended to be a guidance manual for the care of the patient with arterial hypertension, presented for those whose special interests do not lie exclusively in this field.

In it are described those modes of diagnosis and treatment which the authors consider to be important. As much of the theoretical background is given as will make application in practice intellectually satisfying.

The text is developed in a manner which corresponds in the main to the common evolution of the disease and to the progress from examination to treatment. Certain considerations and definitions necessarily preface this development; aspects which do not fit it well are separately considered.

**Approved Laboratory Technique.** Clinical Pathological, Bacteriological, Mycological, Virological, Parasitological, Serological, Biochemical and Histological. By John A. Kolmer, M.S., M.D., Dr.P.J., Sc.D., LL.D., L.H.D., F.A.C.P., Professor of Medicine in the School of Medicine and the School of Dentistry, Temple University; Director of the Research Institute of Cutaneous Medicine; formerly Professor of Pathology and Bacteriology, Graduate School of Medicine, University of Pennsylvania, and Fred Boerner, V.M.D., Associate Professor of Clinical Bacteriology, Graduate School of Medicine and Assistant Professor of Bacteriology, School of Medicine, University of Pennsylvania; Bacteriologist, Graduate Hospital, Philadelphia. Fourth Edition. Cloth. Price, \$10.00. Pp. 1017, illustrated. New York, London: D. Appleton-Century Company, Incorporated, 1945.

The present fourth edition has been heavily revised, largely rewritten and considerably enlarged by the inclusion of newer methods and new illustrations.

A large number of new methods have been included, but older methods of proven value have not been deleted unless replaced by newer ones of greater accuracy and diagnostic value. In many instances two or more methods have been given for the same examinations when it was thought necessary or advisable to do so. As in previous editions, the present book is devoted largely to the technique of laboratory methods and normal values, the changes due to disease and their interpretation being given in a separate book by the senior author on *Clinical Diagnosis by Laboratory Examinations*, also published by D. Appleton-Century Company.

Concerning newer methods discussed, mention may be made of Orlef's indirect method for counting platelets, the Weltman serum coagulation test, the saccharogenic test for urinary amylase as modified by Dozzi, the inclusion of various new tests for kidney function, the congo red test for amyloidosis and nephrosis, the Hanger cephalin-flocculation test for liver function, the qualitative analysis of urinary calculi, the frog test of Weisman, Snyder and Coates for pregnancy, the fluorescent dye method of Richards and Miller for tubercle bacilli, Brewer's plate method for the cultivation of anaerobes, the methods of Reed and Orr for the identification of the Clostridia, the Salmonella group of bacilli in relation to food infections, the cold hemagglutination test of Horstmann and Tatlock for primary atypical pneumonia, methods of detecting the Rh subgroup in relation to blood transfusion, precipitin tests for meningococcus, pneumococcus and Hemophilus influenzae polysaccharides in relation to serum therapy, the serologic tests for syphilis by Boerner and Lukens and Mazzini and the complement fixation tests for lymphopathia venereum, other viral diseases and those due to animal parasites. Special attention

(Continued on Page 22)

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San Francisco

### BOOK REVIEWS

(Continued from Page 20)

has been given the detection of the crystals of the sulfonamide compounds in urine and we are greatly indebted to Dr. John Henderson for the illustrations so kindly furnished. Methods have also been included for testing the susceptibility of bacteria to penicillin and for the demonstration of penicillin in the blood, exudates and other body fluids.

Many new methods have been added to the chapter on methods for chemical examinations of the blood.

**Internal Medicine: Its Theory and Practice.** In contributions by American Authors. Edited by John H. Musser, B.S., M.D., F.A.C.P., Professor of Medicine in the Tulane University of Louisiana School of Medicine; Senior Visiting Physician to the Charity Hospital, New Orleans, Louisiana. Fourth Edition, thoroughly revised. Cloth.

Price, \$10.00. Pp. 1518, illustrated. Philadelphia: Lea & Febiger, 1945.

This book on internal medicine was compiled first for the purpose of giving to the undergraduate student a textbook written by a limited number of well qualified authors who would be able to give the essentials, without allowing the work to become encyclopedic in size and impractical for study, or even handling. Its second purpose was to give to the practitioner of medicine a book on medicine to be used for ready reference, and properly documented so that he could, did he so desire, go to source material or to outstanding contributions to medical literature for more detailed information.

The new material added to the book requires nearly 200 more pages than the last edition, and that in spite of considerable deletion in many sections.

A certain amount of space is devoted to the problems

(Continued on Page 26)

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\* "During pregnancy the average normal woman gains approximately 18-22 pounds, which represents the growth of the uterus, breasts and other organs as well as the fetus and placenta. In other words, a pregnant woman in nine months reproduces tissue almost equivalent to one-fifth of her own normal body weight. It must not be forgotten that the chief function of protein is to supply the tissue-building material of the body, that the need for this material is increased during pregnancy and that the protein deficiency in the diet of the nonpregnant woman may become dangerous when maternity intervenes. . . . It is reasonable to assume that protein foods satisfy appetite earlier than the others and make it content with fewer calories. In this respect we have found high protein diets of value for weight restriction during pregnancy." (Arnell, R. E.; Guerriero, W. F.; Goldman, D. W.; Huckleby, E., and Lutz, A. M.: PROTEIN MALNUTRITION IN PREGNANCY, New Orleans M. & S. J. 95:114 [Sept.] 1942).



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## BOOK REVIEWS

(Continued from Page 22)

of war medicine, notably in conjunction with the protozoan and metazoan diseases and the acute infectious diseases.

**Arthritis and Allied Conditions.** By Bernard I. Comroe, A.B., M.D., F.A.C.P., Associate in Medicine, University of Pennsylvania; Senior Ward Physician and Chief of the Arthritis Clinic, Hospital of the University of Pennsylvania. Third Edition. Enlarged and thoroughly revised. Cloth. Price, \$12.00. Pp. 1359, illustrated with 329 engravings. Philadelphia: Lea & Febiger, 1944.

This third edition contains 13 additional chapters and more than 100 new photographs. Extensive changes have been made in the text.

New chapters have been added on such subjects as penicillin, psychogenic factors in rheumatic diseases,

rheumatic manifestations of tropical diseases, recent advances in arthritis and allied conditions, common mistakes in arthritis and allied conditions. Dupuytren's contracture, diagnostic digest of the average arthritic problem for the general practitioner, effect of climate upon arthritis, occupational therapy, and differential diagnosis of rheumatoid arthritis for the practitioner.

The author states an attempt has been made to bring to the general practitioner the essential points in the diagnosis, differential diagnosis and treatment of arthritis and allied conditions.

Here [America] the free spirit of mankind, at length,  
Throws its last fetters off; and who shall place  
A limit to the giant's unchained strength.

Or curb his swiftness in the forward race?

—Bryant, *The Ages*, St. 33.





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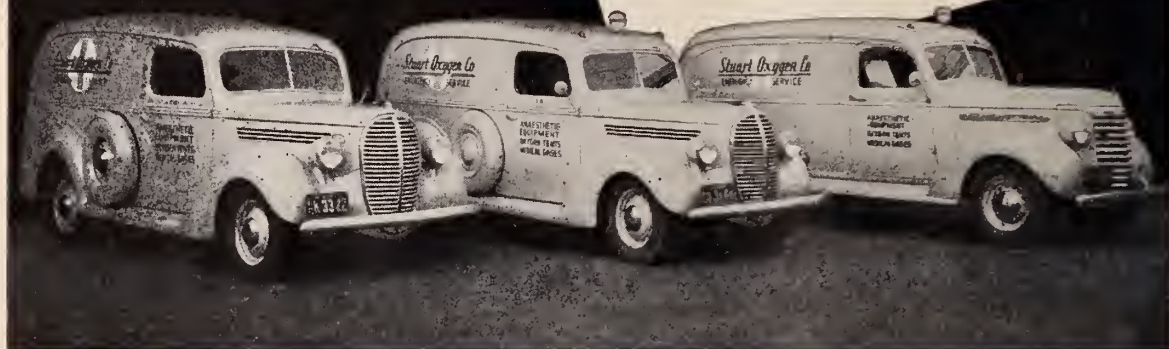
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## TWENTY-FIVE YEARS AGO

(Continued from Text Page 54)

cal profession ramify in countless directions and his neglect of his very great responsibilities has resulted in the trained medical man the world over having no voice in legislative bodies. . . .

Happily the medical profession has the good fortune to have enemies who have roused them from their lethargy of civic inactivity, enemies who by venal methods have sought to retard new or even undo former legislation that tended to advance medical and sanitary science. . . .

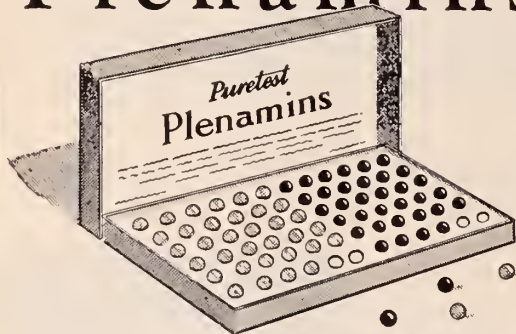
From an Article on "Campaign Issues," by Dudley A. Smith, M.D., President of the League for the Conservation of Public Health, Santa Barbara, May 12, 1920.—A year ago in this very room the League held its first luncheon at a convention of the State Medical Society. When we were invited to fill a similar place on this year's program we accepted gladly; for all the work that we have been doing has been for the upbuilding of the medical profession, and we have been successful in our work because we have received the untiring, enthusiastic and active coöperation of the medical profession throughout the State.

We told you last year that the League was a 365-day organization that was both on and on to its job, always ready for fight or frolic, for emergency or regular service. We had scarcely left Santa Barbara when we were called upon to make good our promises by doing heroic emergency work. . . .

Four Campaign Questions:—There are four questions, however, that are campaign questions this year upon which the League has already assembled sufficient reliable

(Continued on Back Advertising Section, Page 36)

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# CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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NO. 1

## California and Western Medicine

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EDITOR . . . . . GEORGE H. KRESS, M.D.  
*Editorial Board*

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

*Committee on Publications*  
George W. Walker (Chairman) . . . . . Fresno 1946  
F. Burton Jones . . . . . Vallejo 1947  
R. H. Sundberg . . . . . San Diego 1948  
Secretary-Editor . . . . . ex officio

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**BUSINESS MANAGER** . . . . . JOHN HUNTON  
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*Contributions—Exclusive Publication.*—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

*Contributions—Length of Articles: Extra Costs.*—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

*Leaflet Regarding Rules of Publication.*—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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## EDITORIALS

### VII. PROPOSALS FOR A COMPULSORY SICKNESS INSURANCE LAW FOR CALIFORNIA

(Present Series, Concluded)

**Compulsory Sickness and Hospitalization Bills Were Defeated. Interim Study Committees Have Been Appointed by the Legislature.**—When on June 16, 1945, the California Legislature adjourned its biennial session, members of the medical profession heaved at least a faint sigh of relief, since the proponents of compulsory sickness and hospitalization plans had failed in their efforts to have any of their measures enacted into law.

The members of the 56th California Legislature are to be congratulated on their good judgment in refusing to be carried away by the specious pleas and glowing ideologies presented to them by the advocates of the compulsory prepayment plans that had been submitted, and concerning which much space has been given in CALIFORNIA AND WESTERN MEDICINE since January last.

Instead of the proposed laws, the State Senate has appointed an Interim Committee to study prepayment plans, appropriating some \$20,000 to carry on the investigation, giving the Committee power to subpoena, etc., and stipulating a report be submitted to the next California Legislature which will convene in January, 1947. The Senate resolution (Sen. Res. 131) and comments thereon appear in this issue on page 22 (Items VI and VII).

The appointees for the Senate Interim Committee include State Senators Byrl R. Salsman, Chairman, Palo Alto (Santa Clara County), John F. Shelley of San Francisco, Louis G. Sutton of Maxwell (Colusa County), Chris N. Jespersen of Atascadero (San Luis Obispo County), and Arthur H. Breed, Jr. of Oakland (Alameda County).

An Assembly Resolution (H.R. 295) with appropriation of \$50,000, and of similar nature, is printed for its informative value concerning proposed scope and powers of that Interim Committee. At this writing the appointments for the Assembly Committee have not been announced. (See Item XII on page 29.)

**The Threat of an Initiative by C.I.O.—**Unless the C.I.O. group puts into action its threat to present a compulsory sickness insurance law as an initiative to be placed on the State election ballot of November, 1946, or at a special State election prior thereto, (in case the necessary number of valid signatures of voters are secured by the C.I.O., or the Governor in the meantime calls a special session of the Legislature), it may be assumed that the controversial publicity concerning compulsory prepayment sickness and hospitalization plans that has been given so much space in the newspapers, will take on a more quiet tone.

\* \* \*

**Organized Medicine Must Also Carry On Its Studies.**—Since the legislative and executive branches of California's Government have authorized a study of prepayment sickness and hospitalization plans, it follows that organized medicine as represented by the California Medical Association should likewise be carrying on its further studies and collection of factual and other data. The information so secured could be submitted for consideration to the Legislature's Interim Committees. Such steps have already been taken by the Council, a special representative now being engaged in making a first-hand investigation of prepayment plans already in operation in different States. The information obtained and compiled from these various sources will be briefed, and will be sent to Legislators and others who have concern and obligations in finding a practical solution of the problem involved in providing adequate medical care for all groups of California citizens.

\* \* \*

**Responsibility Applies to Every Doctor of Medicine.**—All members of the California Medical Association have a heavy responsibility in this, not only as regards their personal and professional interests, but also because of the debt they owe to the more than 2,000 C.M.A. fellow-members who have answered the call of our Country in its hour of need, and who are in active service in the medical departments of the Army and Navy.

Lay citizens today appreciate the stress and strain under which increased loads bear down on all physicians in civilian practice, but heavy as these burdens may be, they are lighter by far than many borne by colleagues in military service. The rights of these fellow-physicians who are in the Armed Forces must be conserved; not only in relation to obnoxious and impractical compulsory sickness laws, but also as concerns the ultimate replacement of military colleagues in the California communities in which they formerly practiced their profession.

The hope is expressed that every member of the California Medical Association will promptly acquaint himself as fully as possible concerning prepayment sickness and hospitalization plans, and disseminate his opinions thereon to patients and friends.

The Doctors of Medicine of California who

give medical care to the great majority of California citizens start out in possession of the faith and good will of their citizen-patients. Otherwise, these citizens would not be going to these physicians for care during illness. Here is an asset through which public opinion may be molded, if physicians only will first educate themselves concerning prepayment plans of medical care, and then inform patients and friends with their views. The potential possibilities of such support by patients should be translated into active coöperation.

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**County Medical Societies Must Do Their Part.**—In the campaign of self-education of physicians concerning these problems, the component county medical societies also have distinct responsibilities. The president and secretary of every county medical society, in coöperation with the program committee, should take steps to provide not one, but a number of programs, at which various phases of prepayment and social security plans would be discussed. A half hour at each monthly meeting would not be too much to allocate for such purpose. County society members should ask their officers and program committees to inaugurate such round-table or other conferences. If these educational activities are carried on during the next two years, it will aid greatly in the drafting of practical legislation having as its objective, provision of adequate medical care for all groups of California citizens.

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**THOMAS M. LOGAN, M.D., CO-FOUNDER OF CALIFORNIA MEDICAL ASSOCIATION. HIS EFFORTS IN 1872 TO HAVE UNITED STATES ESTABLISH A NATIONAL DEPARTMENT OF HEALTH, WITH ITS CHIEF IN THE PRESIDENT'S CABINET**

**Doctor Thomas M. Logan An Exemplar of Ideals and Achievements.**—In the current issue of CALIFORNIA AND WESTERN MEDICINE, space is given to a biographical sketch of Thomas M. Logan, M.D., who in 1856 joined with Doctor E. S. Cooper to establish the Medical Society of the State of California,\* and who later, in 1870, after a decade of inactivity, brought about its resuscitation.

In this year 1945, the California Medical Association is the fourth (perhaps the third) largest constituent state medical society in the American Medical Association. The great increase in state association membership has taken place in recent years through out-of-state graduates, with only a limited number of new members who are native sons of the Golden State.

A recital of some of the achievements of the exceptional physician who with Doctor E. S. Cooper in 1856 brought our state medical association into existence, and subsequently on October 19, 1870, reestablished it on a permanent

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\* Until 1924 the name of our present "California Medical Association" was "Medical Society of the State of California."



basis, should be worthy of perusal by all California physicians. He was instrumental in having the California Legislature establish a State Board of Health (the second State Board of Health to be established in the United States!), and in 1872 he advocated the enactment of a Federal law to establish a national department of health with its head a member of the Cabinet of the President of the United States, a proposal again coming to the front in Washington, in this year 1945, some 75 years later. From previous comments, the following quotation:

"Referring to Doctor Logan's proposed law for a Federal Bureau of Sanitary Science, submitted on December 13, 1872, to the third session of the 42nd United States Congress, he himself expressed his thought thereon in the following striking manner:

"Instead of being a mere adjunct to the Department of the Interior, there seems no good reason why such a bureau should not, before long, be erected into an independent department, second in its influence and importance to none other. *Let us have a Secretary of Public Health, as well as a Secretary of War.* The achievement of this great national undertaking, as of every other great and good work among men, can only be effected by time and patience, by rational inquiry, and enlightened perseverance. Until this is accomplished, each State must form a plan for the gathering of its own vital statistics, suited to its own circumstances, and must use for this purpose the means it may possess, and the machinery already in operation."

\* \* \*

**California Medical Association is Proud of its Founders.**—At the present time, there are many men and women in the profession who are working harder than ever before. However, contemplation of the zest for professional and associated labor as exemplified in the life of our Founder, cannot be otherwise than an inspiration to all who will take the time to read the sketch in this current issue.

If those of us who are present-day members of the California Medical Association are proud of our membership therein, equally so, may we take pride that our State Association had as its major founder, Thomas Muldrop Logan.\*

#### SHOULD MILITARY HOSPITALS BE ESTABLISHED IN MINERAL SPRING AREAS OF CALIFORNIA?

**Casualty Listings of the Armed Forces.**—On December 7, 1941, Japan made its attack on Pearl Harbor, plunging the United States within the succeeding week, into war with Japan, Germany and Italy. CALIFORNIA AND WESTERN MEDICINE in its recent June issue, on page 361, printed a report stating the War and Navy Departments had suffered casualties in excess of one million personnel during the three and one-half years that have elapsed since the Pearl Harbor bombing. The casualties include more than 600,000 soldiers and sailors who have been wounded. After initial treatment, many of these injured Americans were enabled to return to active combat and other duty, but other thousands have been invalidated home and are now receiving care in

military hospital stations scattered throughout the United States.

\* \* \*

**With War On, Casualties Will Continue.**—The nature and seriousness of the warfare now going on in the Pacific areas is now known to all. Keen observers have stated that the conclusion of the war with Japan cannot be looked for in less than another year or more. Therefore, thousands of additional wounded soldiers and sailors will be brought back to the United States for follow-up medical care and rehabilitation treatment.

\* \* \*

**Where Should Wounded Men Returning to the States be Domiciled?**—Where can these men, suffering from physical and psychical injuries be domiciled to secure for them most efficient care and earliest possible return to military and civilian life? The majority will be sent to military hospitals, but where should these hospital stations be located to promote the best interests of all concerned?

That California, with its great variety of climatic and other conditions, possesses sites of undoubted value for military hospitals cannot be gainsayed. But even in California there are places where climatic, transportation, maintenance and other favorable factors exist in special and desirable combination.

For example, in both the northern section of California (Lake County-Calistoga, for instance) and in the southern portion of the State, are many mineral spring areas, easy of access, where one or more military hospitals could be established to excellent advantage. The military authorities, under existing law, could move in and purchase such a tract or tracts,—just as they have moved into office buildings and hotels of metropolitan centers, taking possession and ownership,—and could erect thereon all necessary hospital structures. In such a place or places, where natural thermal and other mineral spring facilities abound, spa therapy of highest standard, in combination with the best hospital regimen, could be instituted.

Mention could be made of one or more military hospitals that have been set up in California, where topographical and approach surroundings have necessitated expenditure of untold thousands of dollars, without compensatory advantages to the patients who must remain somewhat confined in the wards, because of rolling ground and location of buildings.

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**California Legislature has Twice Petitioned Military Authorities to Establish a Hospital in Mineral Spring Areas.**—Attention of readers is called to a joint Senate-Assembly resolution adopted by the 56th California Legislature, recently adjourned, the text of which appears in the current issue, on page 30.

The joint resolution was again sponsored by Senator George M. Biggar of Mendocino County, to whom thanks are extended.

Two years ago a somewhat similar resolution was unanimously passed by the 55th California

\* Other references to Dr. Thomas M. Logan may be found in CALIFORNIA AND WESTERN MEDICINE as follows: October, 1937, page 250; January, 1940, pages 6 and 27.

See also in "Transactions of Medical Society of State of California," Vol. I, 1870-1871.

Legislature, but for reasons not explained, the medical authorities of the Army and Navy have never followed through with the establishment of a hospital on a mineral spring site. (For reference thereto, see *CALIFORNIA AND WESTERN MEDICINE*, March, 1943, on pages 105 and 137.)

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**On the Value of Mineral Spring Therapy and Spa Regimen.**—An article by Henry E. Sigerist of Johns Hopkins Medical School was referred to, and from it the following excerpts are given:

To the European physician who comes to America it is very striking to find what little use this country is making of its mineral springs. The situation is so totally different from that which prevails in Europe that it calls for an analysis. . . .

Medicinal springs and their curative powers are mentioned by ancient and mediaeval medical writers. . . .

The European spas have been used for over 2,000 years. Medical theories changed. . . .

But whatever the theories were, patients for over 2,000 years went to the spas, bathed in their waters, drank them and found relief. Every medical theory was used to explain the effect of medicinal waters. The explanations changed, but there were always results. In every century patients were benefited by their cures. . . .

It is very unscientific to deny the experience of 2,000 years merely because we have no ready-made theory that explains all phenomena in every detail. It would have been foolish to deny the existence of lightning because electricity was not yet known. Experience has preceded science in medicine more than once. Our most valuable drugs, quinine, digitalis, opium, mercury and many others were given for centuries, long before pharmacology was able to explain their action. Oskar Baudisch has very pertinently shown how similar the situation was with regard to heliotherapy. Sunlight was used as a healing agent for centuries. Rickets were treated with ultra-violet rays. To "scientific physicians" this was a mere superstition—until the vitamins were discovered and it was found that sunlight changes the ergosterol of the skin into vitamin D. Chemistry until recently was gross chemistry; microchemistry is in its infancy still, and we are beginning to realize that a few molecules of a chemical compound can cause definite biological reactions. . . .

\* \* \*

**Not Yet Too Late for Establishment of a Military Hospital on a California Mineral Spring Site.**—If, in the future, additional military hospitals are to be established in California, it is to be hoped that one or more will be erected in a mineral spring area.

In years to come, when such institutions may have fulfilled their immediate and special needs, the grounds and buildings either could be given by the Federal Government to California, or purchased by the State, for maintenance of curative institutions such as Saratoga Springs, owned by the State of New York. In that wise, the money expended, would have doubly justified itself: first, in excellent and desirable hospitalization for many of our wounded soldiers and sailors; and secondly, in making possible in days ahead, promotion of institutional and accessory care to thousands of civilian citizens suffering from chronic conditions, for whom scientific spa regimen, under the California skies, would give better opportunities for reestablishment of health and prolongation of life.

It is difficult to understand why the medical departments of the Army and Navy have not availed themselves of some of Nature's curative means, since institutions established on mineral

spring sites can possess all the advantages of hospitals located elsewhere, with valuable curative elements in addition.

It will be interesting to note whether the new resolutions of the California Legislature will receive serious consideration by the Medical Authorities of the Armed Forces.

## EDITORIAL COMMENT †

### ANTIBIOTICS IN ONIONS AND GARLIC

In 1931 Tokin,<sup>1</sup> Kovalenok<sup>2</sup> and others of the Moscow Laboratory of Experimental Biology, became interested in the volatile antibiotics of certain higher plants, particularly active bacteriocidal vapors given off by raw onions, garlic, horseradish and related plants. Bacteria, fungi and protozoa exposed to these vapors were usually killed within 2 to 5 minutes. They found these vapors ("phytoncides") to be particularly active against staphylococci, streptococci, *B. typhus* and the tubercle bacillus.

Toroptsev<sup>3</sup> and his associates of the Biological Institute, Tomsk University, attempted to determine a possible clinical application for these volatile "phytoncides." Aseptic wounds on rabbits and white rats were exposed for repeated 5-minute periods to concentrated vapors from fresh onion or garlic paste. The volatile antibiotics had a marked stimulating effect on the rate of aseptic wound healing in these animals, both granulation and epithelialization being hastened. The vapors were then used in the treatment of experimental septic wounds. Wounds measuring 1 x 1 cm. were made on both sides of rabbits and the wound surfaces covered with rabbit pus containing streptococci, staphylococci or other pathogens. After inflammation had developed, the wound on one side of each animal was exposed for 15 minutes daily to raw onion or garlic vapor. The untreated control wounds on the same rabbits showed a progressively phlegmatous and necrotic process. There was a rapid sterilization and accelerated healing of all septic wounds exposed to the antibiotic vapors.

So encouraging were these results that phytoncide therapy was applied to the treatment in infected human wounds. Eleven sluggish amputation wounds were selected, seven of the arm, one of the thigh and three of the foot. Eight of the wounds were purulent and contained streptococci, staphylococci or other pathogenic bacteria. In two patients the amputation was complicated by gas gangrene, and one by frostbite. Examination of the extremities before phytoncide therapy showed distinct purulent inflammation of all wounds, with marked edema and odor in most cases. Many of

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.



the patients complained of pain in the amputated area.

To apply vapor therapy, freshly prepared onion paste was placed in the bottom of a prepared dish, which was applied over the wound in such a way that the surface of the wound did not come in contact with the paste. The dish was held in place by layers of cotton. Exposure to the bactericidal vapor was usually performed daily in two 5-minute periods. For each period a freshly prepared paste of one onion was used. After the first vaporization all wounds without exception became rose-colored instead of gray, and the patients no longer complained of pain. Purulence subsided and the odor disappeared soon after the second treatment. By the fifth treatment all patients showed extensive granulation and epithelialization. This was followed by complete and uneventful healing in most cases.

In addition to these volatile bactericidal substances the presence of clinically promising non-volatile antibiotics in onions, garlic and rhubarb has been recently shown by Huddleson<sup>4</sup> and his associates of the Agricultural Experiment Station, East Lansing, Michigan. Onion bulbs, garlic, rhubarb and other plants were finely pulverized in a Waring blender usually with the addition of an equal volume of distilled water. The dilute paste thus formed was filtered through cotton cloth and the resulting turbid filtrate passed through a Seitz filter for sterilization. Serial dilutions of the final clear filtrates were made in tryptose broth, 5 cc. samples of each dilution being inoculated with *E. coli*, *S. aureus* or *B. abortus*. After incubation the presence or absence of turbidity was taken as an index of bacteriostatic activity. Bactericidal activity was demonstrated by negative sub-culture.

Huddleson found that aqueous filtrates from many species of onions or garlic would inhibit growth of all three test organisms in dilutions as high as 1:160. The antibiotics in these filtrates can be heated to 60°C. for one hour without loss of bactericidal properties. The filtrates are inactivated, however, by heating to 100°C. for five minutes.

The active principle can be extracted from these filtrates by shaking them with chloroform. An impure, gum-like substance is obtained by evaporating the chloroform (partial vacuum). The active principle can be extracted from this initial product by its solubility in alcohol, the alcohol-insoluble fraction being inert. On evaporating the alcohol 150 mg of a semi-purified antibiotic is obtained from one pound of onion bulbs, and approximately 500 mg per pound from garlic.

The product thus obtained has many of the properties of penicillin. It inhibits the growth of *Staphylococcus aureus* and other gram-positive organisms in dilutions often as high as 1:600,000. It is relatively inactive against *E. coli* and other gram-negative bacteria. (The volatile *E. coli* inhibiting phytoncide of the Soviet bacteriologists is presumably lost during the process of isolation.

The non-volatile quasi-penicillin is stable in water adjusted to pH 7.3, but slowly deteriorates in the presence of acid (pH above 7.5). The substance is not an aldehyde nor a carbohydrate, its chemical nature otherwise being undetermined. Adequately controlled toxicity and therapeutic tests on experimental animals have not yet been reported.

Huddleson is of the opinion that the main practical value of non-volatile antibiotics of this type may not lie in their use as therapeutic agents, but as preventives of gastro-intestinal infections. "Future studies may assign an importance to their value in the prevention of bacterial and parasitic infections as far reaching as that now assigned to vitamins of plant origin in the prevention of deficiency diseases." He cites no clinical or statistical evidence, however, in support of this belief, and fails to emphasize the fact that the penicillin-like substances in higher plants are rapidly destroyed by cooking, and presumably would be destroyed by the acidity of gastric juice.

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#### Walcher's Position

This was described by Gustav Adolph Walcher (b. 1856) of Stuttgart in a brief article entitled "Die Conjugata eines engen Beckens ist keine konstante Grösse, sondern lässt sich durch die Körperhaltung der Trägerin verändern [The Conjugate of a Contracted Pelvis Is Not a Fixed Measurement, but Varies with the Position of the Woman's Body]," in *Centralblatt für Gynäkologie* (13:892, 1889). A portion of the translation follows:

"If a woman well advanced in pregnancy (my observations were made almost entirely in such) whose pelvis is contracted in the conjugate diameter, be placed on the examining table with the upper part of the body moderately elevated and the knees held as close as possible to the body, the promontory is most easily reached: the diagonal conjugate measures, for example:

- F. (26-year-old para I) 10.2 cm.
- B. 40-year-old para II) 10.3 cm.
- S. (36-year-old para IV) 10.2 cm.

"If a pillow is placed under the sacrum and the legs are allowed to hang down over the end of the table as far as possible, the promontory may be felt to recede with the lowering of the knees. The diagonal conjugate now measures:

- F. 11.1 cm. (a difference of 9 mm.)
- B. 11.6 cm. (a difference of 13 mm.)
- S. 11.0 cm. (a difference of 8 mm.)"

—R. W. B., in *New England Journal of Medicine*.

There is here a great melting pot in which we must compound a precious metal. That metal is the metal of nationality.

—Woodrow Wilson, *Address*, Washington, 19 April, 1915.

## ORIGINAL ARTICLES

## Scientific and General

## THOMAS M. LOGAN, M.D., ORGANIZER OF CALIFORNIA STATE BOARD OF HEALTH AND A CO-FOUNDER OF THE CALIFORNIA MEDICAL ASSOCIATION\*

GUY P. JONES

*San Francisco*

THE Logan family traces its lineage to the ancient and once powerful barons of Scotland. The family became established in America in 1698 with the arrival of Colonel George Logan, a retired English Army officer, at Charleston, South Carolina. His descendants lived the lives of landed proprietors and our story may well begin with young George Logan who in 1750 was sent to Great Britain by his father where he studied medicine at Edinburgh, Scotland, at that time a great center of education. His father was well-to-do, having accumulated considerable wealth through the activities of the members of the family who had preceded him. While a student in Edinburgh, young George Logan fell in love with Honoria Muldrop, the eldest daughter of Christian Muldrop. His Danish Majesty's Counsel for Scotland and the North of England. George Logan obtained his medical degree in 1774 and was married at Leith, Scotland, in 1775. His father was bitterly opposed to the marriage and the young couple remained in Great Britain, most of the time in London, until after the birth of the first child in 1776. The following summer the father of the young doctor relented and sent for the young couple to come to Charleston, and the elder Logan's repugnance to the son's marriage to the Danish girl was completely dissolved. The second son was born in Charleston, January 4, 1778. He, too, became a physician and his son, Dr. Thomas Muldrop Logan, became a pioneer in public health in California and in the United States.

## BORN IN SOUTH CAROLINA

Dr. Thomas M. Logan was born in Charleston, January 31, 1808. The Muldrop in his name was given at the request of his Danish grandmother in remembrance of a beloved brother. In his twentieth year, he married Miss Susan W. A. Richardson, the only daughter of John S. Richardson, who at that time was a judge of the Supreme Court of South Carolina and who had previously served as Attorney General of that commonwealth. Judge Richardson owned large estates in South Carolina and because of his wealth was able to provide funds to send his young son-in-law to Europe for the purpose of advancing his medical education. Young Logan had graduated from the Medical College of South Carolina and for a year or two had practiced his pro-

fession at Clarendon, South Carolina. This opportunity to study in Europe was of tremendous importance and unquestionably was the great factor in determining his career in public health. Leaving his family with his wife's parents, he went to Paris and to Great Britain where he spent many months in the hospitals and lecture rooms of medical centers. In 1828, when young Logan graduated from medical school in South Carolina, medical education was more or less empirical. Scientific medicine was just beginning to develop in European countries. Asiatic cholera first appeared in Europe in 1832 and Logan had the advantage of seeing cases and of studying the disease in Paris.



Thomas Muldrop Logan, M.D., Organizer of California State Board of Public Health.

Co-Founder of California Medical Association (Medical Society of the State of California).

## PRACTICED IN NEW ORLEANS

Upon returning to Charleston, Dr. Logan practiced his profession for several years but without great financial returns. The compensation that he received for his services, in fact, was so small that he became greatly discouraged and after a few years he went to New Orleans where he established a large practice and became a member of the medical staff of the famous Charity Hospital as well as medical director of a government hospital, Lutzenberg, which had been established for the benefit of veterans in the War of 1812. In 1848, the hospital was closed, probably because of the fact that so few veterans of that war remained that hospital facilities were no longer needed.

## SAILS FOR CALIFORNIA

The exact motive that impelled Dr. Logan to leave New Orleans for California is not known but it is presumed that the closing of this hospital coincidental with the discovery of gold in California led to his departure from New Orleans March 8, 1849. At all events, he must have possessed a remarkable spirit of adventure. He was

\* Ed. Note.—For other articles in CALIFORNIA AND WESTERN MEDICINE in which reference is made to the founding of the California State Board of Public Health and to the activities of Doctor Thomas M. Logan, see following issues: June, 1937, page 400; October, 1937, page 250; August, 1939, page 77; and January, 1940, page 2 (Federal Department of Health officially proposed by Thomas M. Logan in 1871), and page 6.

The author of the present article is Mr. Guy P. Jones who entered the service of the California Department of Health in 1911. In 1913, State Health Director William F. Snow delegated him to be the clerk of the State Tuberculosis Commission of which the Editor was chairman. Mr. Jones has been deeply interested in the history of the California Department of Public Health and has gathered many interesting papers concerning its development.



41 years old when he boarded the schooner *St. Mary* for California. This was a small vessel of 75 tons and it was all but wrecked in the tempestuous voyage of nine months. Four months were consumed in doubling the Horn and the vessel did not arrive in San Francisco until January 26, 1850. Its decks were awash most of the time and had it not put into port at St. Carolyn's Island, off the coast of Brazil, it would have run short of provisions. A supply of pigs, poultry, and vegetables was taken aboard and, according to Dr. Logan, these supplies alone probably prevented the development of scurvy in the small crew. The doctor's medicine chest became a total loss as it was soaked with sea water just after the vessel left New Orleans. During the voyage of nine months, no one aboard the vessel was able to keep their clothing dry for any great length of time. When the storm-tossed, weather-beaten schooner docked in San Francisco harbor, its splintered masts were added to the veritable forests of masts and spars that had sprung like magic in San Francisco Bay following the discovery of gold. Almost overnight, the population of the City of San Francisco had grown to five or six thousand and during the next few months following Dr. Logan's arrival, no less than 40,000 immigrants on their way to the gold field had passed through the Port of San Francisco.

#### INITIAL IMPRESSIONS OF SAN FRANCISCO

Shortly after his arrival, he became physician to the Strangers' Friend Society, concerning which no information is available at the present time. He had expected to find an Italian climate but after a short time came to the conclusion that he had been grossly deceived. In writing later to his brother-in-law in New Orleans, he said, "I have passed two rainy and two dry months in San Francisco. I have traveled through one month of spring and two months of summer among the northern mines and have resided near three months of summer and fall in Sacramento City where I am now actively engaged in the practice of my profession, and during all this period, I can conscientiously say that I have not passed one perfectly well or pleasant day." His disillusionment and physical illness caused him to leave San Francisco in April after spending barely four months in that city.

#### JOURNEYS TO SACRAMENTO

In Sacramento, he found that mining camp inundated by the muddy waters of the Sacramento River. After visiting the northern mining regions on the Feather and Yuba rivers, he proceeded to the Mother Lode district, spending most of his time in Hangtown, which was later to become Placerville. In the early autumn of 1850, he returned to Sacramento where he resided for the rest of his life, which ended in February of 1876.

Immediately after his arrival he opened a small hospital on what was then the outskirts of the settlement. At this time, Sacramento extended for about one mile along the river front and its odd collection of tents, shacks, rough homes, and business buildings stretched out on a long finger of land which extended from about the middle of the settlement along the water front. It will be remembered that General John A. Sutter had established a settlement at a point between the Sacramento and American rivers where he constructed a fort which, in reconstructed form, is still standing. This was the nucleus of what was later to become the City of Sacramento. Up to 1844, Fort Sutter was the great trading post of northern California and the commercial life of the region centered about this historic fort. It was here in February of 1848 that a very excited James A. Mar-

shall announced to Sutter his discovery of gold at Coloma in the American River. These flecks of the precious metal introduced a momentous era in the history of the world. The migration that followed was not only one of the most extensive migrations of all history but it also was a factor of great importance in determining the type of civilization and the health of the people who at future times were to reside in this El Dorado. These migrations brought new diseases to the Pacific Coast as well as new strains of old diseases. It was the last frontier of America. For centuries it had lain almost unknown to white men; the formidable barriers presented by the Sierra Nevadas and the broad Pacific had made it the most isolated region on the continent. At this time, California was farther from the Atlantic seaboard, insofar as communication was concerned, than the colonies were from England. It required from 180 to 210 days to journey from New York to San Francisco by way of Cape Horn. Between California and the Atlantic, there lay a vast expanse of unsettled prairies, mountains, and deserts and in order to reach San Francisco by water, vessels were obliged to battle their way around the "Cape of Storms." The isolation of the adventurers who came to California in the gold rush was most complete. They constituted a world unto themselves.

It was into such a situation that Dr. Logan had come. Sacramento had grown from a settlement of 2,000 persons in October of 1849 to a town of 6,500 population in 1850. The first city directory of 1849 described the settlement as a camp having about 300 cloth houses and tents and about 30 camp sites, located in the open air under the trees.



Another photograph of Thomas Muldrop Logan, M.D.: Organizer of California State Board of Public Health. Co-Founder of California Medical Association (Medical Society of the State of California).

#### MORTALITY STATISTICS IN 1849

The mortality in 1849, according to Dr. John F. Morse, was exceedingly high; on some days of December of that

year, there were as many as 20 deaths in a population of 3,500. Immigrants dragging their way along the overland trail arrived in a state of complete exhaustion. Unquestionably, their physical condition was due largely to a lack of proper food as well as to the intense physical hardships that were incurred. Then, too, it must be remembered, that intestinal-borne diseases were carried across the continent by the wagon trains. Water supplied along the route became contaminated and many intestinal diseases, including typhoid and cholera, were carried across the continent by the immigrants.

A temporary city council was organized in Sacramento November 21, 1850, which provided a certain amount of health supervision. The city health department was not established until 1862, however, and it is believed to be the second city board of health to be organized in the United States. A city physician had been appointed several months before at a salary of \$400 per month, for the purpose of looking after the large number of sick immigrants, most of whom were completely exhausted after the ordeal of crossing the continent on foot. The mortality among such individuals in Sacramento in 1849 was tremendous. The hardships of the overland journey, the difficulty in obtaining proper food, and the terrific exhaustion that followed, claimed many lives. Of those who came by water, a large number contracted scurvy, and as a result of their rundown condition suffered other diseases after their arrival. The large numbers of deaths that occurred in Sacramento in 1849 gave the town a reputation as a veritable hotbed of disease. It was not the conditions in Sacramento that were responsible for this reputation but rather the unfortunate conditions of its residents upon their arrival. In 1850 most of the immigrants who, the year before, had come to Sacramento, now stopped at Hangtown (Placerville), which by this time, had become the center of the mining activities in California. From August 1st to November 1st of 1850 there were 700 deaths at Placerville. There was an average of seven deaths each day and on some days there were as many as 20. The unfortunate mortality conditions were thus shifted from Sacramento to Placerville.

#### FORTY-NINER DAYS IN SACRAMENTO

Sacramento was the starting point to the gold fields and the weary travelers who came by way of the overland route were most of them poor, miserable beings, so famished and diseased, or so depressed and despondent, as to make them easy prey of disease and death in a land where they had expected to find only health and fortune. Scurvy-ridden subjects from the ocean began to concentrate with the enormous train of "scorbutic" sufferers coming in from the overland roads, so exhausted in strength and so worn with the calamities of the journey as to be but barely able to reach Sacramento. From these sources, Sacramento became a veritable camp of disease, suffering and death, months before anything like an effective city government could be organized. Dr. John H. Morse, a pioneer physician, said, "It must be recollected that in proportion as these scenes began to accumulate, just in such a proportion did men grow indifferent to the appeals of suffering and to the dictates of benevolence. The more urgent and importunate the cries and exceeding miseries of the sick and destitute, the more obdurate, despotic and terrible became the reign of cupidity. Everything seemed vocal with the assurance that men came to California to make money, not to devote themselves to a useless waste of time in procuring board and raiment for the dependent, in watching over and taking care of the sick, or in the burying of the dead. The common god, Gold, of that day, taught no such feminine virtues, and the King of the County, Cupidity, de-

clared it worse than idle in his subjects to pay attention to the ties of consanguinity or stultify their minds with any considerations of affection or appreciation of human sympathies. Fathers paid little attention to sons, and sons abandoned fathers when they required a little troublesome care. Brothers were fraternally bound to each other, so long as each were equally independent of assistance, but when sickness assailed and men became dependent upon men, then it was that the channels of benevolence were found to be dry and the very fountains of human sympathy sealed by the most impenetrable selfishness. Had this not been the condition, such scenes as were witnessed could not have been exhibited."

Mail came to California by steamer only, until 1857. The isolation of the California El Dorado was intense and the hunger for news of the outside world was ravishing.

#### FEE SCHEDULES IN FORTY-NINER DAYS

Many educated and well-trained physicians were attracted to the Land of Gold and by 1850 there were 90 practitioners of medicine located in Sacramento. Physicians' fees were from \$16 to \$32 per visit. Medicines cost "anything that an attenuated conscience could ask." Thirty-two dollars was asked for one ounce of "basilicon ointment" and obtained. A hospital was established at Fort Sutter where the rates of board and attendance were from \$16 to \$50 per day; pickaxes cost \$12, and pans for washing gold cost \$4. Clerks in stores got from \$300 to \$500 a month and few could be retained at any price, with gold from \$8 to \$16 an ounce. Neither goods nor gold dust was watched with the least care or consideration. Muslins, calicoes, canvas, old sails, brush, logs, boards, iron, zinc, tin and boxes were used in the construction of houses. Public gambling was conducted in magnificent saloons. Traders, mechanics, miners and speculators, lawyers, doctors and ministers concentrated at the gambling tables like flying insects around a lighted candle at night. Gold dust was the only medium of exchange.

#### INTEREST IN CALIFORNIA'S CLIMATE

Dr. Logan brought with him to California instruments for measuring precipitation, temperature and humidity. He had obtained these from the Smithsonian Institution at Washington and immediately began compiling weather records which he continued for twenty years. Upon the establishment of the United States Weather Bureau in 1870, these records were taken over and were made a part of the official records of the Federal Government. He established an office and drug store at 57 K Street. It was customary at that time for physicians to operate a drug store in connection with their practices. A stock of drugs would be maintained upon one side of the room and on the other side were booths, generally covered by black curtains, where examinations were made of patients. At various times he was associated in practice with Dr. John H. Morse, and other leaders among the pioneer physicians. It was not until later years that he established an individual practice, finally establishing a residence and office at 2nd and K Streets, where the first meetings of the State Board of Health were conducted, for the reason that the State Capitol at that time was not completed.

#### ISSUED CALL TO ORGANIZE STATE MEDICAL SOCIETY

Recognizing the need for a State Medical Society and having met Dr. E. S. Cooper of San Francisco and finding that both had similar ideas upon the subject, together they issued a call for the organization of the California State Medical Society. More than a hundred physicians were present at the first meeting in April of 1856. The



American Medical Association had been organized but a few months before and the total attendance at that meeting was not more than 50. Considerable enthusiasm was developed at this meeting. It must be recognized that at this time there were many types of physicians—those who had had the best training available, those who had had no medical training whatsoever, and a third element which had no special motives aside from the accumulation of wealth and who were known as idlers. All of these different types of practitioners were admitted to the medical society with the idea that the unfit would soon eliminate themselves.

The society had rough sailing and finally in 1859 came to an abrupt end, existing only on paper until 1870, when none other than Dr. Logan accomplished the herculean task of reorganizing the society and becoming its president. The immediate cause of the dissolution of the society in 1859 was a report of the committee on obstetrics of which Dr. Beverly Cole was chairman. In this report, the chairman of the committee spoke of the women of California in terms which were regarded as insulting by members of the society who had come from southern states. The report stated that many of them were diseased victims of dissipation and fashionable life. Under the title, "The State Libel," one of the southern physicians said:

"Again, if so many married women are diseased as the professor of obstetrics says, where are the signs in the children? More healthy children were never born. The golden age did not furnish more beautiful children than gladden the hearts of thousands of virtuous, happy, cheerful mothers in this heaven favored center of new civilization. We prophesy that children born in this State will constitute the type of a highly improved variety of the human species. They will be braver and larger than their fathers, the daughters as handsome and virtuous as their mothers, and the latter are unsurpassed by any in the world. Shame, that one should live so shut out from the genial air of heaven, so isolated from decent people as for a moment to imagine such degradation. Look up, ye stupid libelers of your mothers and sisters and daughters, to the serene sky above you. Let your bleared eyes, that forever contemplate lust and debauchery, look away to the mountains that gird our horizon in solemn grandeur. Ascend our city's hills and listen to the Eternal anthem of the ocean and occasionally visit our magnificent temples consecrated to the service of the ever-living God, that your minds may be able to contemplate something more worthy of science and human nature."

Following this outburst, most of the southern members of the society, including Dr. Logan, walked out. The State Medical Society was dead for 10 years. Dr. Logan, however, spoke or wrote no protest but, according to the dictates of southern chivalry, expressed his disapproval by his withdrawal.

#### FRIENDSHIP WITH DR. ELIAS SAMUEL COOPER, FOUNDER OF SCHOOL OF MEDICINE OF STANFORD UNIVERSITY

Logan's friendship with Cooper must have been based upon Cooper's remarkable skill as a surgeon. He had come to San Francisco in 1855. He had considerable trouble in Illinois, where he had been accused of robbing cemeteries in order to obtain cadavers. Logan, Cooper and Lane together visited Smith's Pomological and Floral Gardens, two and a half miles east of Sacramento on the American River. The agriculturists will be interested in knowing that in 1857 in these gardens there were 3,000 peach trees of 75 varieties, 20 varieties of strawberries, 10,500 grape vines of 60 varieties. In 1856 peaches were

sold for \$19,178, strawberries for \$2,294, and from the nursery \$5,097 worth of trees, flowers and plants, of which Mr. Smith had 700 different species. In addition, \$2,579 worth of garden produce and \$3,027 worth of seeds were sold, bringing the total receipts for one season to \$32,175.

Dr. Logan was possessed of considerable talent as an artist, for in Morse's Medical Journal there appears a statement to the effect that "our fellow-townsmen, Dr. Thomas M. Logan, has painted a picture of fruit from Smith's Pomological and Floral Gardens, which should be reproduced and distributed throughout the United States for the purpose of attracting people to California."

Cooper died in 1862. He had organized the first medical school on the Pacific Coast, known as the Medical Department of the University of the Pacific, which was afterwards reorganized as the Medical College of the Pacific, in later years becoming Cooper Medical College, endowed by his nephew, Dr. Levi C. Lane. Cooper suffered from a nervous affliction and together with Lane journeyed through the mountain districts, stopping at Sacramento in an effort to recover his health. He had rested many weeks at Saratoga before this trip, but while at Sacramento he was told by Lane that he could not possibly survive. He returned to San Francisco to settle his affairs before returning to Illinois, whence he had come. Death overtook him, however, and he died within a week after returning from the goldfields. He was only 40 years old when he died. He was known as a bold, enthusiastic and original surgeon. Much of his success was due to the use of alcohol on his instruments. He made his reputation in San Francisco by a sensational operation, removing successfully a breech-pin of a fowling piece from beneath the heart of a boy. All other surgeons in San Francisco had refused to operate. The operation was successful to the boy and to Cooper, but the latter gained the everlasting enmity of the medical men of San Francisco.

#### DR. LOGAN'S WRITINGS AND OTHER ACTIVITIES

From 1860 to 1870, Dr. Logan wrote continually for the medical journals and he presented reports to the Sacramento Society for Medical Improvement\* on the medical history of California. Most of his writings were on climatology and meteorology as related to health. In 1867, he made a trip to Europe, spending several months visiting medical institutions in France, England and Germany. Upon reviving the State Medical Society in 1870, his address as president covered mortality of California. In 1870 and 1872 he published his report on the "Annual Museum for the Exhibition of the American Medical Association in Philadelphia and the Contributions from California." At the meeting in Philadelphia in 1872 he was elected president of the association and when presiding at the St. Louis meeting in 1873 he discussed medical education and State medicine. After becoming permanent secretary of the State Board of Health in 1870, he took up such matters as ventilation of school rooms and prevalence of special diseases. He believed firmly in a National Health Council [National Department of Public Health, with Chief as a member of the cabinet of the President of the United States], and wrote long arguments favoring the establishment of such a council. He wrote extensively on the subject of malaria, tuberculosis, vital statistics, regulations concerning the dead, use of intoxicating liquors, salubrity of public institutions and dozens of other subjects, many of which are actively discussed today. He was president of the Agassiz Institute in Sacramento, which was organized in 1872, following the personal appearance of Agassiz on the Pacific Coast.

He was meteorologist of the State Agricultural Society and an honorary member of the Imperial Botanical and Zoological Society of Vienna. He continued as secretary of the State Board of Health until his death in February of 1876.

Room 611, Phelan Bldg., 760 Market Street.

\* \* \*

Editor's Note.—Because of their relationship to Author Jones' historical sketch, some brief excerpts from minutes of the first meeting of the "Medical Society of the State of California," on its reorganization on October 19, 1870, as printed in Volume I—"Transactions of the Medical Society of California," are here given. (The name of the state medical association was changed from "Medical Society of the State of California" to "California Medical Association" on June 23, 1923, at which time the House of Delegates adopted a new constitution.) Excerpts from the meeting of October 19, 1870, follow:

(COPY)

TRANSACTIONS OF  
THE STATE MEDICAL SOCIETY OF CALIFORNIA  
During the Years 1870-71  
REORGANIZATION OF THE SOCIETY

In pursuance of a call issued by the State Board of Health, for a Convention to reorganize the State Medical Society, a number of physicians met in the hall of the Young Men's Christian Association, in San Francisco, October 19, 1870.

The meeting was called to order at 10½ o'clock A.M., by Dr. T. M. Logan, of Sacramento, on whose motion Dr. James L. Ord, of Santa Barbara, was chosen Chairman. Dr. George Hewston, of San Francisco, was appointed Secretary.

At the request of Dr. H. Gibbons, Sr., Dr. T. M. Logan, through whom, as Secretary and executive officer of the State Board of Health, the meeting had been called, delivered an address of welcome, and explained the objects in view, as follows:

Gentlemen: In consequence of the part I have taken, as the executive of the only organization representing, in any degree, the profession of the State, in calling you together, it becomes my privilege, as well as my duty, to thank you sincerely for this your cordial response. Fourteen years ago [1856], in association with the lamented Cooper, who was the leading spirit of the occasion, I officially signed the call, as Corresponding Secretary of the Sacramento Society for Medical Improvement, for a Convention in that city, to inaugurate the scheme which we are now assembled to resuscitate. The objects for which the State Medical Society [Medical Society of the State of California] was formed did then, as they do now, enlist my warmest interest and command my active coöperation; and, judging from the intelligent—many of them old familiar—faces around me, I have reason to believe that I entertain these views and professions only in common with you all.

Prior to this organization, as most of you well remember, the medical mind was in a state of inertia—the profession in a chaotic condition. The dominant materialism of the Golden Age, which had invaded every department of human activity, and inverted the natural order of things by subjecting the higher to the lower, was degrading medicine into a mere business, leading men of real ability, who might have been remembered as benefactors of their race, to spend their noble energies in building up an extensive practice, irrespective of the means, by which alone the much-coveted prize could be secured. But no sooner were the clarion notes of our call sounded, than a new spirit was awakened, and from their sheltering privacy, in all parts of the State, volunteers poured in, and threw their souls into the movement which was to

purify and regenerate the prostrated glory of their calling. I need not remind you how the dim line of demarcation—so dim as scarcely to have been seen before by the professional eye—was then drawn so decidedly between false and sterling merit, that even the materialists, who relied upon the influence of cliques to be sustained, were obliged to chime in for a time with the overwhelming movement.

Nor need I recall the varied subsequent experience, which has but confirmed that of all other reformatory proceedings, that it is only by the slow workings of time that radical and lasting changes can be effected. As the formative crystal and the germinal cell which your microscopes reveal, are but the hidden sources of the mightiest elemental forces or of the most intricate developments of organic life, so the primordial movement which we are now assembled to further and consolidate, was but the beginning of the inborn power which is still animating the great body of the profession, and carrying it onward in its legitimate course. Had the State Society done nothing else than concentrate in its perfect and unexceptionable constitution and code of ethics this great uprising of the profession, and conserve its subsequent transactions through publications, it would have performed a service entitling it to an imperishable name in the medical annals of our country. But it has done more than this; and we proudly point, among its results, to our medical colleges, our monthly periodicals, our numerous local societies, and our municipal boards of health, and last, but most exultingly, to our recognition in the legislative councils, by the engrafting of a State Board of Health on our statute book. These are only some of the results, patent and manifest to even the most skeptical, proving how our profession has been moving onward and upward since the great impetus given to it in 1836....

## RHEUMATOID SPONDYLITIS\*

WITH SPECIAL REFERENCE TO EARLY DIAGNOSTIC CRITERIA

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MEDICAL CORPS, ARMY OF THE UNITED STATES

Santa Barbara

THE frequency with which we have encountered rheumatoid spondylitis in young males of military age has surprised us. In one period of eighteen months more than seventy-five such cases have been admitted to Hoff General Hospital. These represent one of every four patients with rheumatoid arthritis. Since roentgen therapy, if given early, has been found effective in alleviating the symptoms and interrupting the progress of the disease,<sup>1,2,3</sup> a prompt diagnosis is important. Furthermore a diagnosis of rheumatoid spondylitis has explained most bizarre and misleading symptoms, clarifying atypical abdominal and radicular complaints.

Rheumatoid spondylitis has been known variously by such names as ankylosing spondylitis, Marie-Strumpell's disease, Von Bechterew's syndrome and adolescent spondylitis. Most American writers agree that the name rheumatoid is properly applied, since it apparently is a spinal localization of the rheumatoid arthritis which is seen peripherally. This is supported by strong clinical, radiographic and histopathological evidence. The etiology is unknown. Foci of infection have been suspected as

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Fig. 1.—Normal sacro-iliacs showing pear-shaped cartilaginous portion.

Fig. 2.—Stage 1, rheumatoid spondylitis. The joint margins are broken and indistinct.

have been infectious diseases, climate and body habitus. None of these have been apparent in our series to a significant degree. A causal relationship between gonorrhea and rheumatoid spondylitis has been suggested.<sup>4</sup> Of the fifty cases studied in detail five have had recent infections and seven remote and apparently unrelated infections. This is approximately the frequency which had been noted in fifty patients with chronic rheumatoid arthritis of the extremities. As is so frequent in peripheral rheumatoid arthritis, a history of injury is obtained in most cases of rheumatoid spondylitis. In this connection it is of interest that Scott<sup>2</sup> was impressed by the increased frequency of this condition among young athletes.

#### PATHOLOGY

Pathologically the changes are those of rheumatoid arthritis elsewhere, and involve the true joints of the spine.<sup>5,6</sup> These joints are the apophyseal, sacro-iliac and costovertebral articulations. Clinically a vague history of joint pains of transient type is frequently obtained. Chronic low back pain, accompanied by stiffness and aching, fluctuating in intensity is noted. Radicular pain is not uncommon and may be the most prominent symptom. Examination characteristically reveals tenderness over the sacro-iliacs or lumbar spinous processes, paravertebral muscle spasm, limitation of lumbar motion, straightening of the lumbar curve and, in the more advanced cases, atrophy of the lumbar muscles. This gives a characteristic "ironed out" appearance to the lower back. The sedimentation rate is consistently elevated, a significant finding in differentiating rheumatoid spondylitis from other causes of low back symptoms, in judging the degree of activity and the efficacy of treatment.

#### ROENTGENOGRAPHIC DIAGNOSTIC CRITERIA

The roentgenographic diagnostic criteria are based primarily on the identification of typical rheumatoid arthritic changes in the sacro-iliac and apophyseal joints. We have observed no instances of apophyseal joint involvement without definite sacro-iliac manifestations. This is in contrast to the work of Oppenheimer,<sup>7</sup> who found 14 per cent of his cases to have normal sacro-iliacs when definite diagnostic changes were present in the apophyseal joints. The finding of bilateral rheumatoid changes in the sacro-iliac joints in the early stages has led to a more thorough search of the posterior intervertebral articulations and often the subsequent identification of minimal changes in these joints. Since these changes are often to be classified as "plus or minus" it is felt that the sacro-iliac lesions are uniformly more advanced and more definite, and for practical purposes more readily

accessible by x-ray. The simple AP projection of the lumbosacral spine has proven the most satisfactory for demonstrating the pathological changes present. Stereoscopic films were used in the earlier cases, but it was soon found that a careful scrutiny of the outline of the so-called "pear" or inferior cartilaginous portion of the joint on single films yielded as much information. Films taken with the tube or the patient angled are often misleading and do not readily lend themselves to comparative study of the two sides. For the apophyseal joints 45 degree angle films give the best visualization.



Fig. 3.—Stage 2, rheumatoid spondylitis. Almost complete loss of definition of the sacro-iliacs is apparent.

#### RADIOGRAPHIC FINDINGS IN SERIES REPORTED

The radiographic findings in the sacro-iliac joints are the basis of classification of the fifty patients into three groups. The first group includes those cases which show the most minimal sacro-iliac changes which can be defined. The second group is intermediate and shows more marked modification or involvement of the sacro-iliacs but none of the advanced, burned out appearance of the third group. This last group includes the examples of the classical end stages of rheumatoid spondylitis with fusion of the sacro-iliacs and marked calcification of the spinal ligaments.

*Group 1.*—In group or stage one there are twenty-four cases. These all exhibit minimal sacro-iliac changes with or without manifestations in the apophyseal joints. The sacro-iliacs first show a loss of definition of the fissures which make up the boundaries of the cartilaginous pear. In twenty-two of the twenty-four cases these changes are bilateral, although by no means are they always sym-

metrical in extent or degree. The appearance can best be described by such terms as "hazy," "blurred" or "ground glass." The sharp, penciled double lines about the "pear" become broken or disappear, and the margin therefore is broadened and irregular. The entire cartilaginous portion may assume a mottled or honey-comb appearance with complete absence of outline. Very little if any change in the adjacent portions of the sacrum or ilium is noted in stage one cases. At the most a mild reactive zone of increased density is apparent. In the apophyseal joints a slight demineralization or a single cystic rarefaction of one or more articular surfaces is the usual finding. The most marked case shows a mottled increase in density about several apophyseal joints entirely similar to the honey-comb changes noted in the sacro-iliacs. There is no rarefaction of the vertebral bodies and no ligamentous calcification in these stage one cases. A striking feature has been the loss of the normal lumbar curve which, when present, has directed us to a more careful scrutiny of the sacro-iliacs. Posture on the table can seldom account for the straight alignment noted on the films.

*Group 2.*—In the moderately advanced phase or second stage there are 19 cases. This group shows more marked sacro-iliac manifestations, which are usually accompanied by definite apophyseal changes, especially in the lumbar area. The sacro-iliac joint space is completely without definition and often shows marked cystic change. Rarefaction of the adjacent ilium is frequent as is mottling and a loss of trabecular definition. The changes are often more marked on one side than on the other and the posterior or more medial margin is invariably more completely obliterated than the anterior. In eight of the nine-

teen cases the "pear" shows complete fragmentation and loss of all contours and in two of these there is marked periarticular demineralization. Five instances of so-called "rosary" formation or scalloping with cystic caries of the joint margins have been encountered. No true fusion is apparent in any case of the second group. In the apophyseal joints erosion with roughening or scalloping of the facets is visible and the joint spaces become narrowed. Interestingly all degrees of dissolution, cystic change and fusion have been apparent in the same spine with completely normal facets at intervening levels. Such findings further our decision to classify cases on the basis of sacro-iliac changes.

There is definite calcification of the spinal ligaments in nine group two cases, although in only one case is calcification completely visualized from one bony structure to another. This case is a border line stage three with complete bridging in the lower dorsal area. The sacro-iliac joints, however, are not fused. The costovertebral articulations have not been adequately studied but it is apparent that they are involved in most instances when the adjacent apophyseal joints show significant modification.

*Group 3.*—There are only seven cases in the advanced or third group. This phase has long been stigmatized as the characteristic picture of chronic rheumatoid spondylitis. It includes examples of the disease ranging from ankylosis of the sacro-iliacs and one or more apophyseal joints with or without ligamentous calcification to extensive ankylosis of all the diarthrodial joints of the entire spine including the costovertebral articulations. Extensive calcification of the paravertebral ligaments, the intraspinous ligaments and the ligamenta flava in one or



Fig. 4.—Stage 3, the sacro-iliacs are fused.



Fig. 5.—Stage 3, calcified ligaments, the "poker spine."



in practically all segments may be present, giving rise to the typical roentgen picture of the "bamboo spine." Fusion of the sacro-iliacs is partial in six of these seven advanced cases but complete in only one. In all instances some fragmentation is still present. All demonstrate marked calcification of the spinal ligaments with establishment of true poker spines, more pronounced in the lower dorsal and upper lumbar regions. The absence of universal complete bony ankylosis is attributed to the relative youth of the patients. Residual activity is evidenced by fragmentation accompanied usually by a deposition of calcium in the small detached portions and about the margins of cystic excavations. This results in a general appearance of active mineralization in the joint spaces and periarticular ligaments.

#### CONCLUSIONS

It is important that rheumatoid arthritis of the spine be recognized in its earlier phases. This is distinctly a radiographic problem. The first changes which can be defined are found in the sacro-iliacs and the apophyseal joints, and consist of a general loss of definition, dissolution of the subchondral portions and demineralization of the periarticular bony elements. The physical findings in this earlier phase are not reliable. The sedimentation rate is most significant in the differential diagnosis, in judging the degree of activity and in estimating the response to treatment. Radiotherapy is apparently effective in arresting the progress of the disease.

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## VOLUMINOUS VENTRAL HERNIA\*

SURGICAL REGIMEN FOR THE ENORMOUS INCISIONAL EVENTRATION

#### REPORT OF CASE

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WHEN dealing with a large ventral hernia it is well to always bear in mind a gem from Theodore Kocher, namely "Wer seinen Bruch zu solchen dimensionen anwachsen lässt, mag ihn auch ferner behalten" — "He who permits a hernia to develop into such dimensions should retain it."

The history of such a case as in the one here presented is usually that of a patient who has been operated upon years previously for suppurative or ruptured appendix—wherein the nerve supply to the anatomical abdominal layer has been injured or improper muscle-fascia healing has occurred. The patient usually observes a small swelling at the site of the scar and this swelling gradually develops into a large hernial mass. Meanwhile over such a long period of time the individual anatomy and physiology have become adjusted to the large hernia and thus do not give sufficient symptoms to force the patient to resort to surgical intervention.

In considering procedures for a large ventral hernia, the surgeon should first ask himself the questions: (1) Is the operation safe; (2) Is the operation necessary and (3) If the surgery is safe and necessary will it benefit the patient? After these premises have been satisfactorily passed, the surgeon should then consider the weight of his patient and the possibility of reducing the weight of his patient before surgery. By lessening the excessive obesity the surgeon-physiologist makes his surgery less difficult and safer from both a cardiovascular

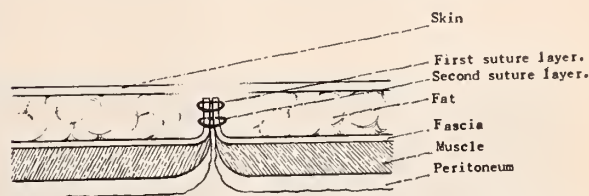


Fig. 1.—Cattell's technique of suturing opposed wall surfaces.

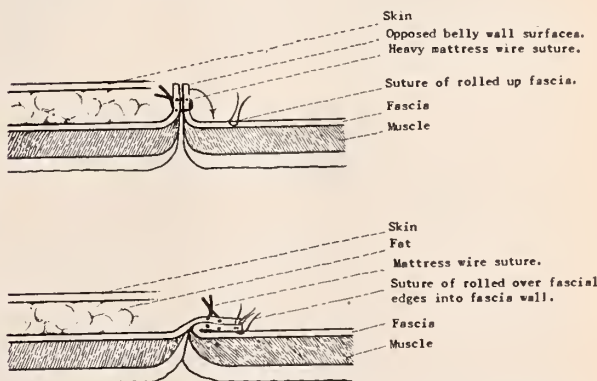


Fig. 2.—Author's method of surgical repair of voluminous ventral hernia.

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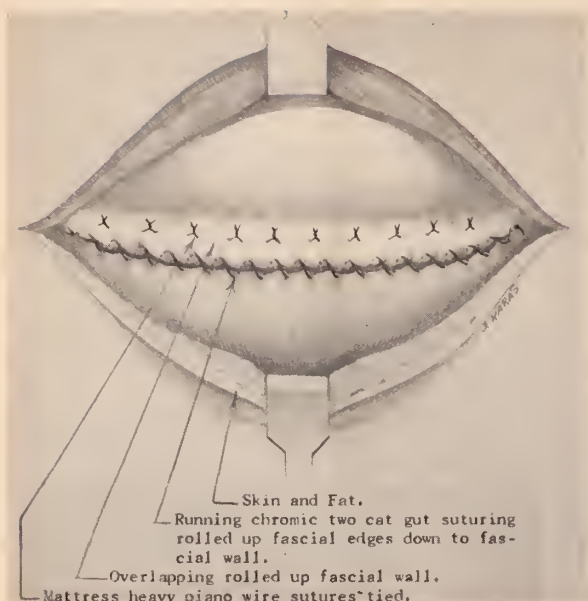


Fig. 3.—Skin flaps and fat retracted to show sketch of author's case, with ten mattress wire stitches and the rolled up fascial edges sutured down to fascial wall.

as well as embolic standpoints; and the success of his surgery becomes more probable.

Possible anatomical factors of repair must be considered. The larger the hernial sac, the greater will be its contents, and the less room there will be for those same contents when replaced in the abdomen, since the abdomen may have adjusted itself over a ten year period, as in the author's case. The surgeon must consider whether the patient's muscle-fascia tissue will be suffi-

ciently strong to "hold up" after the mass of organs have been replaced back into a cramped space. The sutures must be strong enough to hold the increased strain until nature has aided by fibro-plastic repair.

The shock involved must not be overlooked, nor the changes in intra-abdominal and intrathoracic pressure when the great mass of omentum and intestines is replaced in the normal abdomen. A life saving factor in the postoperative treatment which the author uses as a routine measure is to prevent ileus from the beginning, by placing a Levine duodenal tube in situ before surgery and then keep the patient decompressed for at least three critical postoperative days. Many of these patients have died during this immediate postoperative period from both asphyxiation as well as severe shock and ileus, all because of a lack of prevention through the use of gastro-intestinal decompression. If we first decompress our patient, we automatically greatly decrease the tension on sutures, since the sutures are put to such a great test in holding together the widely separated fascia over an increased intra-abdominal tension.

#### SURGICAL PROCEDURE

The preparation of the obese patient for this tedious prolonged operation is very important. He enters the hospital for a twenty-four hour rest period, during which period his liver glycogen reserve is built up, and elimination obtained by multiple enematas in order to thoroughly decompress the gastro-intestinal tract. The abdomen is treated with a twenty-four hour surgical preparation of tincture merthiolate which is then sealed with a large sterile surgical dressing. Just preceding surgery the entire abdomen is again painted with tincture merthiolate, which is allowed to dry well before draping. All such operative wounds are surgically sealed after the operation, and are left unmolested for eight days. It is felt that frequent dressings interfere with natural tissue



Fig. 4.—Voluminous ventral postoperative hernia (side view). Entire wall of belly separated 8 inches at site of ruptured appendix. Hernial contents of bowels, stomach and omentum would fill a large milk pail.





Fig. 5.—Postoperative cure—two years after radical surgery.

repair and at each dressing a potential contamination of the clean wound is always possible.

All anatomical abdominal layers should be dissected out widely and radically. Intestinal and omental adhesions should be carefully separated from the anterolateral belly wall. Generally, the large fat adherent omentum should be radically resected, because it is the bombardment of the omentum against the belly wall with each inspiration that causes so many recurrent hernias. Thorough hemostasis and rigid asepsis must be carried out. After the abdominal layers are thoroughly freed so that they fall together without too great tension, the peritoneum is closed with running chromic No. 1 catgut stitch. Silver wire sutures are used as mattress through and through fascia and muscle. At times it is necessary to suture the entire abdominal wall-peritoneum, muscle and fascia with through and through wire sutures. This can be done safely if the walls can be brought together in complete apposition at the time the wire sutures are tied. The free edges of fascia are approximated with a running chromic No. 2 suture and then rolled up laterally to attach firmly into the fascia. The author feels that rolling up the free edges of fascia, after first wiring the opposed walls together with carefully placed mattress heavy piano wire sutures, tends to further strengthen the suture line. Actually a firm thick rope-like fascia is thus obtained directly over the formerly weak region. It is believed that in certain selected cases of an enormous hernia in obese patients that rolling up of the fascial edges by suture laterally, as a rope, back on to the fascial wall, as a routine procedure, makes for a stronger belly wall than to use Cattell's method of two suture layers. In many cases Cattell's method is a more simple and quicker technique and should be used when time is a factor. Retention button sutures are also used with No. 5 deknatel silk. The abdomen is sealed by strapping with tape in a rather firm fashion, and the patient treated expectantly with continuous decompression, intravenous fluids and oxygen inhalation.

In the author's case there was no tissue reaction of any kind. Tissues healed kindly and remained healed by primary intention and without one drop of serum, even though the wide hernial opening required ten mattress heavy wire sutures in closing the fascia. The patient in question has been working at all classes of labor for two years since surgery was done, and with no complaint of any kind and no weakness. In fact, his operative scar remains unusually firm and thickened due to rolling up the fascia in suturing. Rolling of fascia makes for far greater strength than edge to edge suturing.

#### REPORT OF CASE

**CASE 1.**—White male; age 37; weight, 220 pounds; height, 5 ft. 5 in. Gives history of ruptured appendix with peritonitis, in 1930. Six months later he noticed a small swelling at the lower angle of his right rectus scar. This swelling gradually became larger until about 1935, when he states that his hernia was the size of a water-melon and it was necessary for him to "carry it around" with him. He could hear gurgling noises in the large mass and whenever he would roll over in bed he would have to lift the huge tumor mass over, in order to change position. He contacted different hospitals and was advised that his obesity and condition was too extreme to ever be cured.

Physically, his findings were all normal except for his obesity and enormous ventral postoperative hernia, which came through an opening in the fascia that was over eight inches in diameter. The entire hand could drop down through this opening, and palpate the scarred, thick fascial muscle edges of the ring.

The patient's weight was reduced about 25 pounds and, after he was advised that there was only a 50 per cent chance of success, the operation was performed.

**Operation.**—The hernia sac contained all of the small and most of the large bowel, stomach and huge fatty omentum adherent everywhere. A radical omental section was done and all fascia and muscle layers were dissected, far out to either side. All adhesions of bowel to the abdominal wall were severed.

Innumerable hot packs were used throughout the four-hour operation to prevent shock to the viscera. Also, intravenous fluids were used during surgery.

The peritoneum was closed with chromic gut, and muscle fascia scarred layer was approximated with mattress heavy wire sutures; suturing together surfaces rather than edges, similar to a technique proposed by Richard Cattell. The free opposing surfaces, approximately one-half inch of fascia with muscle, purposely devised redundant tissue above the mattress sutures, was now "rolled" laterally by running chromic two catgut suture into the firm fascial wall. (See drawing.)

It is felt that Cattell's technique here is an admirable one but that one can not always adopt a set procedure to all types of anatomy. In this patient, I used Cattell's method of opposing surfaces, but used a different type of sutures, and method of suturing. (See drawing.) Scrupulous technique was used in suturing, so that not a single minute region was overlooked in the repair. As much as possible, the muscle tissue was sutured with the fascia, in order to retain circulation and thus improve healing. The patient remained in a hospital bed for three weeks after surgery.

Chromic gut, silk and fine wire were first in the fascia, but the tension necessary to hold together the wall was sufficient to quickly break these sutures, and thus it was necessary to resort to heavy wire. After a stormy three-day postoperative period, the patient made an uneventful recovery.

Gastrointestinal decompression, oxygen therapy, and intravenous fluids were used from the first postoperative day.

This patient was passed physically 1A by the United States Army, but he insisted they x-ray his abdomen. The examination revealed a row of 10 mattress silver wire stitches in the abdominal wall. The Army advised him they could not pass anyone so full of safety pins.

Observation three years after surgery was done, proves

that he is well and strong, with a very firm belly wall. The scar retains its thick cord-like consistency. In conclusion, it is humbly suggested that this is one of those few exceptions in major belly surgery, where complete fearlessness and surgical confidence in radical procedures completely overshadows all wishful conservatism if a real cure is to be expected.

#### SUMMARY

1. Photographs are presented showing patient with an enormous postoperative ventral hernia, and with surgical cure. Postoperative photographs were taken of this abdomen after two years following surgery, to be sure that no recurrence was to occur.

2. A series of facts in surgical judgment regarding ventral hernia surgery are listed.

3. Certain life saving factors peculiar to a large ventral hernia are stated: (a) decompression of gastro-intestinal tract; (b) oxygen therapy, and (c) shock treatment.

4. Silver wire suture material seems to be ideal for this type of surgery in that it gives proper tensile strength, with no tissue reaction of any kind.

5. A surgical procedure of rolling up the fascia in repair of ventral hernia is described.

6. The difference between success and failure (often death of the patient) in this type of radical surgery is dependent on surgical judgment and meticulous attention to detail, before, during and following surgery.

Note: (a) No sulphanilamide was used in this wound. (b) For relaxation of this huge belly wall and for safety factor, a combination of spinal novocaine nupercaine and cyclo-propane gas anesthesia were used.

U.S.S. McIntyre (APA-129) c/o Fleet P. O., San Francisco.

### ABSCESS OF THE TONGUE\*

LIEUTENANT COLONEL CAMILLO V. BERNARDINI  
MEDICAL CORPS, ARMY OF THE UNITED STATES

**A**BSCESS of the tongue, acute suppurative glossitis, acute parenchymatous glossitis, or lingual abscess, has been reported in the literature by various writers at very infrequent intervals. The condition must be a rarity as Bennett<sup>1</sup> who made an exhaustive study of this entity compiled a series of 145 cases from the literature over a period from 1816-1906. He reported one case himself. Then in 1914, Loeb,<sup>2</sup> Raynor<sup>3</sup> in 1915, Prenn<sup>4</sup> 1916, Cavanaugh<sup>5</sup> 1918, Wilensky and Harkavy<sup>6</sup> 1923, Barlow<sup>7</sup> 1925, Hansel<sup>8</sup> 1928, Vandevere<sup>9</sup> 1929, Mahoney<sup>10</sup> 1932, Syme<sup>11</sup> 1934, Grigsby and Kaplan<sup>12</sup> 1937, Salinger<sup>13</sup> 1941, Gerwig and Dick<sup>14</sup> 1942, and finally McLaughlin and Davis<sup>15</sup> in 1942, completing the series of abscess of the tongue. In all cases reported to the present writing, including the present one, a grand total of 186 have been accumulated, the vast majority appearing as single case reports, while several authors have had the opportunity to see two patients.

This condition attracted the attention of the writer to the extent that he recalled one other case before seeing the present one, in an elderly man during his internship days who succumbed, but the attending surgeon evidently did not deem it worthy in reporting as it has not been found in the literature. Fifteen years later, while on duty with troops out of the continental United States, the case being reported presented itself for treatment, being the only occasion since the case that succumbed in which the writer has had the opportunity to observe this condition.

There are varieties of glossitis commonly found and existing secondarily to other diseases, such as in avitaminosis, pernicious anemia, hemorrhage with swelling of tongue in scurvy, leukemia and several causes of purpura. We are not concerned with conditions in presenting this article.

#### ETIOLOGY

Age is of no significance as Bennett, Gerwig and Dick, and McLaughlin and Davis have pointed out in their reports. The condition attacks individuals in good health, and occurs about three times more often in males than in females. The winter and spring months when upper respiratory infections prevail seem to have some bearing as a predisposing cause. More direct causes are exposure to wet and chilling; ragged and decayed teeth along with poor dental hygiene; small wounds of the tongue which become infected, such as tooth bites, irritations from buried bristles from tooth brushes, and fish bones; sore throats and upper respiratory infections already mentioned; exanthemata; injuries to the jaws; and some have observed patients in which the abscess developed without history of trauma or other conditions enumerated above being present. The bacteria isolated by the several authors and observers show usually mixed infections, the staphylococcus predominating. In the order of frequency the bacteria named are as follows: staphylococci, streptococci, diphtheroid bacillus, and the pneumococci.

#### ANATOMICAL LOCATIONS OF ABSCESES

Nearly one-half of cases reported involve the whole tongue; while a majority involve the left side only; about one-fourth of the series found shows that the infection begins on one side of the tongue and then extends to the opposite side, or a subsidence occurs and then a recrudescence takes place on same side. No explanation is given by any of the writers why the left side is most frequently involved. The report by McLaughlin and Davis discusses in detail the pathology and the several anatomical and physiological reasons why an acute suppurative process rarely develops within the substance of the tongue.

#### SYMPTOMS

Pain is a cardinal symptom from the very beginning. If the condition could be seen from the onset of illness, no explanation can be accounted for the amount of excruciating pain described by the patient, as it is out of all proportion to the objective findings. Prenn gives in the description of his case that the pain simulated that of tic douloureux, while pain of tic douloureux is also trigger-like in character. Hansel describes his case in which the patient's pain was trigger-like. The pain is then followed by stiffness of the tongue, swelling and dysphagia, with salivation, and impairment of speech, with general malaise and elevation in temperature take place in a few hours. Temperature may vary from 97.8 to 104.4 degrees F. Also, the patient may give a history of having had a sore throat and not having felt well for the past several days, attributing the other symptoms found to that condition. Dysarthria, furring and coating of tongue, fetor oris will soon follow, and as the tongue swells more and more, the mouth is kept open and the organ protrudes from the oral cavity, showing teeth impressions on the tongue. As the condition progresses the patient becomes restless and his breathing labored, the respiratory cycle being more of an anxiety type than due to the obstructing influence of the swollen tongue. Externally, the submaxillary and cervical lymph glands become swollen and tender on the affected side, or both, if the entire organ be involved. The physician will have

\* This article has been released for publication by the Review Branch, War Department Bureau of Public Relations. The opinions and views set forth in this article are those of the writer and are not to be considered as reflecting the policies of the War Department, or the military service at large.



much difficulty in examining the tongue by digital palpation due to the extreme tenderness of the organ. As the condition advances, the patient takes on an appearance of being worn out and facial characteristics take on an anxious expression.

Edema of the glottis, suffocation, hemorrhage, descending infections into the mediastinum, lungs and pericardium, are the more serious sequelae. The attending physician should be prepared to perform an immediate tracheotomy, and the patient should not be left unattended until the crisis be over. Only 3 per cent of cases reported have terminated in death.

Approximately one-fourth of cases end by resolution in five to fifteen days, the remainder proceeding to abscess formation and suppuration in two to seven days. When incised and adequately drained the organ returns to normal in three to five days, a slight induration remaining for several weeks following the operation as in other abscess conditions occurring in other parts of the body. One case has been reported in the literature in which the glossitis subsided by resolution, but the tongue remained hard, indurated and tender for five years, and when an incision was made into the area, a large amount of pus, foul in character, was evacuated, followed by immediate and complete recovery. Still another case had three recurrent attacks extending over a two-year period. No more attacks followed when filling defects in various teeth were repaired.

#### TREATMENT

The treatment outlined in a majority of cases reported is purely symptomatic, palliative and supportive. Mouthwashes, gargles of sodium perborate, saline and soda mixture are used freely; cracked ice, liquids and fruit juices by mouth; ice bags or fomentations applied to the neck; acetylsalicylic acid, codeine and the sulfonamide drugs, will help. Parenteral administration of glucose and saline solutions should be resorted to if it becomes necessary, and we must not forget blood transfusions in cases of hemorrhage and to combat infection. Gerwig and Dick were the first to use sulfathiazole in treating this malady with 100 per cent results in their two cases. Should the glossitis proceed to abscess formation, incision and drainage is the treatment of choice. Adequate sulfonamide therapy should be given following the operative procedure for prophylactic measures and to prevent an extension of the abscess. The anesthetic most frequently used is novocaine by infiltration. Prenn and Syme, have suggested general anesthesia with the patient in the sitting position. Mahoney used the electric cautery in both his patients without anesthesia, and reported only moderate discomfort.

#### REPORT OF CASE

A white noncommissioned officer, age 22, presented himself at the station hospital on September 30, 1941, complaining of intense pain and swelling of the tongue, the condition beginning about two days previously. He was drooling excessively and had an impairment of speech, mumbling his words. He had been on outpost duty with his platoon in very inclement weather for about a week, and denied having received any injuries to his jaw, or biting his tongue. However, he thought that several days before the pain began while brushing his teeth a bristle from his tooth-brush had penetrated into the left side of his tongue but he could not find it and allowed the incidence to go by until the intense pain appeared two days ago, and which was on the following day of the purported injury to the tongue. Physical examination revealed a well-developed, medium built, slightly drawn and haggard-looking infantry sergeant. His weight was 120 pounds (normal 135 pounds).

Temperature was 97.8 F., pulse 84 and of good quality, and respirations 18. Patient claimed that a doctor on an island had given 10 grains of acetylsalicylic acid several hours before for relief of pain, and after examination referred him to the station hospital for further treatment.

His skin was clear and not flushed. Eyes were normal and reacted to light and accommodation. Nose examination was essentially negative.

The mouth was held open by the swollen tongue with a profuse flow of saliva and foul odor coming from the oral cavity. There were impressions of teeth marks on anterior portion of tongue, the organ being swollen markedly, edematous, coated, furred and an elevation showing more toward the posterior and left side. The tonsils and throat could not be visualized at this examination, or at subsequent ones due to the engorgement of the posterior portion of the organ. By digital palpation an indurated area could be felt but no fluctuation was present. All teeth were found to be in excellent condition and the gums were negative. The left cervical and submaxillary lymph glands were swollen and tender. No abnormal breath sounds were heard in the lungs. Heart sounds were normal. Although the patient complained that he had a shortness of breath, there was neither dyspnea nor cyanosis present.

The laboratory findings were as follows: Blood pressure 110 systolic and 82 diastolic; R.B.C. 4,650,000; hemoglobin 85 per cent; W.B.C. 12,300; polys 73 per cent; lymphs 21 per cent; eosinophils 4 per cent; and large monos 2 per cent. The urinalysis was negative, other than for a few pus cells present. Treatment was supportive and symptomatic, with acetylsalicylic acid and codeine for relief of pain, cracked ice by mouth, fruit juices and water ad lib., and patient placed in the semi-Fowler position with icebag to the affected side. A tracheotomy set was held in readiness with the necessary antiseptic and novocaine solutions in anticipation for any emergency.

On October 1, sulfathiazole medication was instituted. By this time patient had to be given light doses of morphia to relieve the pain. The swelling seemed to be localizing in the posterior portion of the tongue, upper side, and slightly to the left of the medium raphe, but still no fluctuating mass could be palpated. However, by now the tongue was so tender to touch that this method of examination was unsatisfactory. The temperature remained around 99° F., pulse 80, and good quality, with the respirations still 18. Patient's general condition was good. He was having difficulty in swallowing liquids, but cooperated to the fullest.

On October 2, his temperature rose to 100.4° F., pulse 120 and respirations 26. Patient complained that breathing was becoming more difficult but there was no evidence of obstruction of the air passageway, and no cyanosis was present. His facies showed anxiety and fright. Later in the day the patient was taken to the surgery and after infiltrating the tongue with 1 per cent novocaine solution, abscess was incised and drained. Approximately one and one-half ounces of thick, putrid pus drained from the left posterior lateral third of the tongue. Relief as expressed by the patient was immediate. He was able to swallow without discomfort 15 hours after operation. Sulfathiazole therapy was given for another 72 hours, and when no more exudate could be seen coming from wound was discontinued. By October 6, the engorged tongue had receded almost to its normal size and but for some induration in the incised region no objective signs could be seen. On October 8, the patient was discharged to duty, weighing 128 pounds, but was kept under observation for several months following his discharge from the hospital. No recurrence of the condition has taken place and the sergeant was hale and hearty six months later, weighing 135 pounds, and performing full duty.

#### SUMMARY

1. A case of acute suppurative glossitis is presented with a résumé of the literature on the subject.
2. The several methods of treatment are given.
3. Local infiltration anesthesia seems to be the anesthetic of choice of most of the cases reported in the literature.
4. We must consider the entity as a rarity, for no author or observer has reported more than two cases.
5. The prognosis of lingual abscess is excellent, 97 per cent of cases recovering.
6. Of all reported cases, 3 per cent were deaths from the condition. It could be possible that physicians have not taken the trouble to report deaths from this entity, as there is a reluctance in reporting cases that terminate fatally.

87th Field Hospital, APO 331, c/o P. M., San Francisco.

(For References, see page 13)

# CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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† For roster of officers of component county medical societies, see page 4 in front advertising section.



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 Schultz, William I., *from Inyo-Mono County to San Bernardino County*  
 Zimmerer, Stella Lehr, *from Riverside County to Los Angeles County*

## In Memoriam

**Brumbaugh, Donald Harmon.** (Lieutenant Commander, United States Navy.) Killed in action in the Pacific theater, date of death unknown, age 42. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1931. Licensed in California in 1931. Doctor Brumbaugh was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Gafford, James Albert, Jr.** (Lieutenant, United States Navy.) Killed in action in the Pacific theater, date of death unknown, age 39. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1931. Licensed in California in 1931. Doctor Gafford was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Kapp, Michael William.** Died at San Jose, June 12, 1945, age 79. Graduate of the Cleveland Medical College, Homeopathic, Ohio, 1895. Licensed in California in 1905. Doctor Kapp was a Retired Member of the Santa Clara County Medical Association, and the California Medical Association.

✱

**MacBeth, William Lewis Colquhoun.** Died at El Monte, March 1, 1945, age 59. Graduate of the University of Toronto Faculty of Medicine, Ontario, 1909. Licensed in California in 1927. Doctor MacBeth was a

member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

**MacPherson, William Alexander.** (Captain, United States Army.) Killed on the USS Comfort, April 28, 1945, age 38. Graduate of the College of Medical Evangelists, Loma Linda, 1935. Licensed in California in 1940. Doctor MacPherson was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Nevius, Fred Porter.** Died at Oakland, June 14, 1945, age 63. Graduate of Michigan College of Medicine and Surgery, Detroit, 1906. Licensed in California in 1922. Doctor Nevius was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Porporato, Albert John.** (Lieutenant, United States Navy.) Killed on the USS Comfort, April 28, 1945, age 39. Graduate of Creighton University School of Medicine, Omaha, Nebraska, 1932. Licensed in California in 1933. Doctor Porporato was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Pressley, James Fowler.** Died at San Francisco, May 25, 1945, age 71. Graduate of the University of California Medical School, Berkeley-San Francisco, 1902. Doctor Pressley was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Zander, Charles Henry.** Died at Oakland, June 15, 1945, age 65. Graduate of the University of Minnesota Medical School, Minneapolis, 1909. Licensed in California in 1925. Doctor Zander was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

*Aubrey Beardsley (1872-1898).*—Aubrey Beardsley, during an artistic career of barely five years, produced in that brief period work of rarest excellence. His black and white drawings are of strange and fantastic originality and continue to exert an influence upon contemporary art. He never permitted anyone to see him work. Day or night, he labored by candlelight—by the light of long tapering candles that so often found pictorial expression in his extravagant designs. Like the poet, John Keats, Beardsley was tuberculous and died in his twenties. —Warner's *Calendar of Medical History*.

*E. B. Browning (1806-1861).*—At sixteen Elizabeth Barrett was injured while attempting to saddle her pony. This afterward led to the development of tuberculosis. Although invalided since twenty, she gallantly carried on and became one of the few great women poets. Her father had made his daughters promise not to marry, but when love came her way at thirty-eight, she braved the sorrow of family alienation to enjoy the rare blessings of a happy marriage with Robert Browning. —Warner's *Calendar of Medical History*.

## CHAPTER VII

RE: COMPULSORY HEALTH INSURANCE  
BILLS SUBMITTED TO THE 56TH  
CALIFORNIA LEGISLATURE

Commencing in January, 1945, CALIFORNIA AND WESTERN MEDICINE presented a series of editorials and many collateral items relating to proposed sickness and hospitalization insurance laws submitted to the California Legislature, which began its 56th session on Monday, January 8, 1945.

The proposed legislation had a vital relationship to public health and medical practice interests. It was important that a full report should be made for the information not only of C.M.A. members who were in civilian practice, but for the more than two thousand C.M.A. colleagues who are in military service. Also, as a matter of historical record.

In this current issue, with items under Chapter VII, the series will be completed.

For the convenience of readers who may be called upon to refer to the sickness insurance proceedings of the 56th Legislature, the following index is given:

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## ITEM I

## The Latest Social Security Proposals

With the introduction by Senator Wagner of a new bill on Social Security, the questions of broadening the present coverage, increasing benefits and including provision for some type of health or hospital insurance again demand full examination.

That there be broader Social Security coverage is generally viewed as desirable; both of the major political parties in their 1944 platforms advocated this. Under Senator Wagner's new bill the coverage would be extended to an additional 15,000,000 persons, including farm workers, domestics, those in nonprofit institutions, independent farmers, professional persons and small businessmen.

While the press dispatches refer to the bill as "a new concept of Social Security, including health insurance" the outline of the principal provisions do not indicate

in detail how they vary from those in the Wagner-Murray-Dingell bills which died on the adjournment of the 78th Congress. Representative Dingell, who is joining Senator Wagner in the new move, had reintroduced the former bill in the House in January.

Under the new bill, contributions from employers and employees would be increased from 1 to 4 per cent each; in the old bill the proposed unified system of social insurance including unemployment and old-age insurance as well as health insurance would have been financed by a total payroll tax of 12 per cent, divided evenly between the worker and the employer with 3 per cent allotted to health insurance.

The need for a thorough study of the entire Social Security program and its method of financing has long been apparent. In both the present and previous session of Congress, Senator Vandenberg has introduced resolutions calling for a joint committee to make such a study.

When such questions of increasing existing benefits and inclusion of new benefits are under consideration, the first essential is the consideration of the cost. An inadequately financed program obviously is to be avoided. Costs which levy a tax burden on payrolls that hamper business and industrial activity will result in unemployment and benefits can be increased beyond the point where the most desirable results are to be obtained. The present use of Social Security tax receipts for other governmental purposes is another matter needing attention with relation to the system's reserves. While the Treasury I.O.U.'s bear interest, they represent future obligations of taxpayers who, of course, include those who have already paid the Social Security taxes.

Although Senator Wagner says that none of the current voluntary hospital insurance plans would be affected under his proposal for such coverage, it is not clear how this would be true unless the bill provided for specific exemption of members in voluntary plans. The start that such voluntary plans have made appears to support the view that with proper exploitation they can accomplish the desired objectives.

The proposal that unemployment insurance be nationalized rather than operate on a state basis incurs the objection that its operation would not be as satisfactory and abuses likely would be greater rather than less.—Los Angeles Times, May 25, 1945.

(Ed. Note.—For digests of Wagner-Murray-Dingell bills (S. 1050 and H.R. 3293), see in JUNE CALIFORNIA AND WESTERN MEDICINE: comment on page 306, Item X on page 352, and Item XXVI, on page 359.)

## ITEM II

Warren Suggests Lobbying Investigation As  
Hospital Bill Appears to Be Doomed

*Statement Follows Charge of Assembly Speaker That Governor, Too, Has Been Something of a Lobbyist on His Measure*

Sacramento, June 5.—Governor Warren today suggested it was the "appropriate time" to investigate lobbying activities around the Legislature after the Assembly had administered what appeared to be final defeat to a hospital care insurance plan the Governor sponsored. Just how such an investigation could be undertaken was not made clear. (In San Francisco, Attorney-General Robert Kenny said he considered the remedy political, at the ballot box, rather than legal.)

With most major issues out of the way, both houses of the law-making body voted to adjourn June 16.

The Governor's statement followed a charge from the rostrum of the Assembly by Speaker Charles Lyon (R., Beverly Hills) that the Governor had "reduced himself to the point of lobbying" for the hospitalization insurance bill.



### Wollenberg Brushed Off

Speaker Lyon made the statement in ruling Assemblyman Albert C. Wollenberg (R., S. F.), an author of the bill, out of order when Mr. Wollenberg attempted to read a message the Governor sent to the Legislature advocating the measure.

Governor Warren declared at a later press conference that a Governor was ordered by the Constitution to send recommendations to the Legislature "on such matters as he shall deem expedient." He then read the constitutional section which defines lobbying as influencing a legislator's vote by dishonest means, and makes it a felony.

"I can see no connection between the two," Governor Warren said, "but if there is any question as to whether any activities surrounding the Legislature fall into the category of lobbying, I would suggest that it might be an appropriate time to make a full and impartial investigation regardless of who is concerned."

"The Legislature is the judge of its activities except when they are criminal. . . . I think if there's any question of illegal activity in the Legislature it is in the Legislature's own interest to investigate," he said.

### "Only in Comment"

Governor Warren made it clear that he was making the statement only in commenting on Speaker Lyon's charge.

The Governor added that he felt "extreme regret" over the Assembly's decision to leave the hospitalization plan in the public health committee. The committee had tabled it previously and there apparently were no remaining maneuvers open to get action on the measure at this session, following defeat of the withdrawal motion by a 45-to-32 vote.

Assemblyman Wollenberg said he was "surprised" at Speaker Lyon's stand.

"Apparently he wants a Governor who sits by and lets his program get kicked around. The lobbying engaged in by the opposition to the health bill has been the strongest in my experience in the Legislature," he added.

Points of order were sustained by Speaker Lyon at least four times halting supporters of the hospital care insurance bill when they verged onto discussion of merits of the bill itself, rather than the motion to withdraw it from committee. Rules of the house limit debate to the motion.

When Assemblyman Gaffney (D., S. F.) arose, however, to protest against the wide scope of remarks against the bill by Assemblyman Ernest Debs (D., Los Angeles), Speaker Lyon said merely:

"You're too late. He has finished making his point."

When Assemblyman Raup Miller (R., Palo Alto) stated he had amendments ready for the bill, and wanted a chance to introduce them, Mr. Debs suggested he go back to the committee; maybe they would lift the bill from the table. . .

"No, I don't think they would," said Mr. Miller shortly.

The clash between Mr. Wollenberg and the Speaker was sharp, with both talking at once, and the air filled with the incessant beat of the gavel as Speaker Lyon tried to halt Mr. Wollenberg.

"I insist on the point of order," Speaker Lyon said. "You know you are out of order reading that statement. I so rule."

"I won't contest it," Mr. Wollenberg said, "but I want to say you may feel I am out of order, but I certainly do not know or think any such thing."

He turned then to the Assembly, which had grown suddenly still and alert, and said: "You have seen here in this argument exactly what attitude this bill has been up against and the other health insurance bills all through this session."

"The action of the Speaker illustrates it as much as anything I can say. I ask for an aye vote."

### How Assemblymen Voted

All San Francisco assemblymen voted in favor of bringing the bill out of committee. Thirty-two Republicans voted against it.

### Votes In Favor

*Republicans* favoring withdrawal of the bill from the public health committee, to permit floor debate—Burns, Carey, John C. Lyons, Maloney, Miller, Sheridan, Sherwin, Thurman, Wollenberg.

*Democrats*—Anderson, Beck, Bennett, Berry, Brady, Brown, George D. Collins, Crichton, Dekker, Ralph C. Dills, Doyle, Dunn, Fletcher, Gaffney, Haggerty, Hawkins, Helsing, Kilpatrick, Massion, McMillan, O'Day, Pelletier, Rosenthal.

Total—32.

### Votes Against

*Democrats* voting against withdrawal—Allen, Beal, Burkhalter, Crowley, Debs, Clayton A. Dills, Emlay, Evans, Guthrie, King, Lowrey, Middough, Robertson.

*Republicans*—Armstrong, Boyd, Burke, Butters, Call, Clarke, Sam L. Collins, Davis, Dickey, Erwin, Field, Fourt, Gannon, Geddes, Hollinbaugh, Johnson, Knight Kraft, Leonard, McCollister, Niehouse, Price, Stephenson, Stewart, Stream, Thompson Thorp, Waters, Watson, Weber, Werdel, Charles W. Lyon.

Total—45.

*Absent or Not Voting*—Republican Denny, Democrats Sawallisch and Thomas; total—3.—San Francisco *News*, June 5, 1945.

## ITEM III

### Assembly Kills Lobby Quiz Bill

Sacramento, June 15.—By a vote of 29 to 47, the Assembly today killed the resolution calling for investigation of illegal lobbying practices.

The action was taken in refusing to withdraw the legislation from the powerful rules committee, where it had been bottled up.

### Two from San Francisco

Of San Francisco's eight assemblymen, only two voted for the withdrawal. They were Albert C. Wollenberg (R.) and George D. Collins, Jr. (D.) . . . —San Francisco *Call-Bulletin*, June 15.

## ITEM IV

### Publication, "Labor," Lauds Warren

Governor Warren's fight for prepaid medical care in California has won him an accolade from a powerful section of labor.

"*Labor*," weekly publication of the 21 railroad brotherhoods, said editorially in its current issue that Governor Warren should win reelection next year "by a majority which will concentrate national attention on the gallant fight he has made" in the Legislature to provide every Californian with reasonable medical care.

*Labor* said the program was defeated by lobbyists but that Warren should make it the principal issue in the Republican primary. It said organized labor would support him.

Raymond Lonergan, labor columnist, said the lobbyists defeated the program in spite of a prayer by House Chaplain Torrance Phelps "for the representatives of the special business and professional interests to put the interest of the entire state above mere personal interests and profit."

"Probably that's the first time in the history of American Legislatures that lobbying became so flagrant that a

chaplain felt he should direct God's attention to the evil practice," Lonergan commented.

Yet the Legislature shut its eyes to this disgraceful fact by refusing to authorize a lobby investigation.—Editorial in *San Francisco News*, June 18.

#### ITEM V

### California Medical Association to Offer Health Plan in Legislature

#### *California Physicians Making Nationwide Study of Insurance*

Sacramento, June 12.—The California Medical Association is preparing a "positive, workable program" for voluntary health insurance, for presentation either at the 1947 regular session of the legislature or a special session at an earlier date, it was disclosed today by Dr. Philip K. Gilman, Association president.

A specially hired expert, Doctor Gilman revealed, is now making a nationwide survey to develop a "fair and equitable" plan.

Observers interpreted these activities of the C.M.A. as the organization's answer to recent criticism by Governor Earl Warren, who declared that the medical men, although opposing his program for compulsory prepaid medical or hospital care, had failed to offer any constructive counter-recommendation.

#### Two Failed

Two bills sponsored by the Governor failed to emerge from the assembly committee on public health, and no further attempts to enact a compulsory program are possible this session.

The new C.M.A. plan came to light when Doctor Gilman appeared before the assembly committee on finance and insurance to oppose Senate Bill 1036 which, Doctor Gilman contended, would permit hospital corporations to engage in medical and surgical services as well as hospital care. The bill failed to receive sufficient votes on a "do pass" motion and remained in committee.

#### Study Plans

"The Association now has a special committee," Doctor Gilman said, "to study ways and means of devising a comprehensive plan for voluntary health insurance, including both medical and hospital care.

"This committee has a full time expert now touring the United States to make a first hand, full time study of all State legislation on the subject, of all existing plans and how they work, and to find out the good and bad, so that from the experience all over the country a positive, workable program can be prepared.

#### C.M.A. Program

"When this program is ready the C.M.A. will present it to the next session of the legislature for such legislation as may be necessary, either general or special.

"Before any legislation on the subject of health insurance is enacted, we want to get all of the facts from all over the country and analyze and sift them until we have a real plan that will be fair and equitable and will actually work."—R. W. Jimerson, in *San Francisco Examiner*, June 13.

#### ITEM VI

### Health Insurance Seen Issue of '46 State Election Campaign

Sacramento, June 18.—Health insurance was projected today as a major 1946 gubernatorial campaign issue as members of the Legislature struggled in a heat wave towards belated adjournment.

With clocks stopped in both houses, it appeared that the end of the session, originally scheduled forty-eight

hours ago, could not occur until late tonight or early tomorrow.

#### Senate Far Behind

The Senate was far behind the Assembly in its work.

Legislators labored without their \$10 a day expenses, which terminated Saturday. Their \$12 a day pay stopped last month when a 100 day time limit expired.

In the closing hours, the Assembly followed the Senate in setting up a separate interim committee to study health insurance after earlier refusing to enact a program recommended by Governor Warren.

However, at the reported instance of the Governor, who intends seeking reelection, the Assembly's enabling resolution was amended to provide that its investigating committee must report back to him and the Legislature by July 1, 1945.

#### Special Session

If favorable to health insurance, the report may mean a special session of the Legislature immediately thereafter. But, in any event, it is considered certain to be an issue in the final fall election campaign after the June primary, if not before.

The Assembly committee, proposed by Assemblyman James G. Crichton (D.), Fresno, will have seven members with \$50,000 for expenses.

The Senate committee, suggested by Senator Byrl Salsman (R.), Palo Alto, will have five members with \$20,000 to spend. . . —*San Francisco Call-Bulletin*, June 18.

#### ITEM VII

### Senate Interim Committee on Prepayment of Medical and Hospital Care\*

The *Senate Journal* of the 56th California Legislature in its issue of June 16, 1945, on page 3978, printed the text of the Senate Interim Committee Resolution on Study of Prepayment Medical and Hospital Care systems, with report thereon at the 57th Legislature.

The text of the Senate Resolution follows:

*Senate Resolution No. 131*—Relative to the creation of a Senate Interim Committee on Prepayment of Medical and Hospital Care.

WHEREAS, The cost of medical and hospital care limits its availability to many, and inflicts serious financial damage to others, thus rendering the people of the State physically or economically less fit; and

WHEREAS, Programs for the prepayment of such costs have been devised and recommended, and the Legislature will again at its next session be confronted with similar measures, in which there is a large popular interest, and will be required to take such action as the facts revealed to it warrant, and

WHEREAS, More pertinent facts can be considered by the Legislature if the opinions, practices, and arguments of those interested are first weighed and tested by an investigating committee; now, therefore, be it

*Resolved by the Senate of the State of California*, as follows:

1. The Senate Interim Committee on Prepayment of Medical and Hospital care is hereby created and appointed and authorized and directed to ascertain, study and analyze all facts relating to the cost of adequate medical and hospital care and the relationship of that cost toward its availability, and the effect of such cost on the health and happiness of the people; the extent to which programs of private groups and organizations afford such care, the equity of the distribution of the cost thereof, and the classes of persons who are eligible for or participation in such program; the desirability of the adoption of a program administered by the State, and the

\* For editorial comment, see page 1.



policies under which such a program should operate; and the experience of State operated plans in other countries; including but not limited to the operation, effect, administration, enforcement and needed revision of any and all laws in any way bearing upon or relating to the subject of this resolution, and to report thereon to the Senate, including in the reports its recommendation for appropriate legislation.

2. The committee shall consist of five members of the Senate appointed by the Committee on Rules thereof, and vacancies occurring or existing in the membership of the committee shall be filled by the appointing officer.

3. The committee is authorized to act during this session of the legislature, including any recess, and after final adjournment until the commencement of the next regular session, with authority to file its final report not later than the fifteenth legislative day of the next regular session.

4. The committee and its members shall have and exercise all of the rights, duties and powers conferred upon investigating committees and their members by the provisions of the Joint Rules of the Senate and Assembly and of the Standing Rules of the Senate as they are adopted and amended from time to time, which provisions are incorporated herein and made applicable to this committee and its members.

5. The committee has the following additional powers and duties:

(a) To select a chairman and a vice-chairman from its membership.

(b) To cooperate with and secure the cooperation of county, city, city and county, and other local law enforcement agencies in investigating any matter within the scope of this resolution and to direct the sheriff of any county to serve subpoenas, orders and other process issued by the committee.

(c) To report its findings and recommendations to the legislature and to the people from time to time and at any time, not later than herein provided.

(d) To do any and all other things necessary or convenient to enable it fully and adequately to exercise its powers, perform its duties, and accomplish the objects and purposes of this resolution.

6. The sum of twenty thousand dollars (\$20,000) or so much thereof as may be necessary is hereby made available from the Contingent Fund of the Senate for the expenses of the committee and its members and for any charges, expenses or claims it may incur under this resolution, to be disbursed, after certification by the chairman of the committee, upon warrants drawn by the State Controller upon the State Treasurer.

Resolution read.

The roll was called, and the resolution adopted by the following vote:

*Ayes*—Senators Biggar, Breed, Brown, Burns, Carter, Collier, Crittenden, Cunningham, DeLap, Deuel, Dillinger, Donnelly, Fletcher, Gordon, Hatfield, Hulse, Jespersen, Keating, Kuchel, Mayo, McCormack, Mixter, Parkman, Powers, Quinn, Rich, Salsman, Seawell, Shelley, Slater, Sutton, Swing, Tenney, and Weybret—34.

*Noes*—None.

#### ITEM VIII

##### The Doctor and Group Insurance

In the *Connecticut State Medical Journal* for May, 1945, page 344, appeared an article by Harlan S. Don Carlos on "The Doctor and Group Insurance."\*

Some excerpts from this article are of special interest, in view of the recent attempts to enact a California law to cover sickness and hospitalization insurance. A covering letter and excerpts follow:

(COPY)

THE TRAVELERS INSURANCE COMPANY

Hartford, Connecticut, June 13, 1945.

To the Editor:

It occurs to me, in view of your cooperative interest in our Group Insurance question at Lockheed in January, 1944, you might be interested in the enclosed reprint, which represents the readiness of The International Claim Association to cooperate with the medical profession in making a better job of the Group Insurance coverage by private insurance companies.

Sincerely yours,

(Signed) HARLAN S. DON CARLOS,  
Manager, Life, Accident and  
Group Claim Department.

Excerpts follow:

Fourth, is the hospital and surgical coverage which pays a stated amount per day during hospital confinement up to a certain number of days, reimbursement for special hospital charges, such as x-rays, laboratory, use of operating room and anesthetic, up to a specified amount, which is usually five times the daily hospital indemnity rate and, in addition, reimbursement for the surgeon's fee for surgical procedures up to maximum amounts stated in the schedule printed in the policy. This coverage, with minor modifications, is available to the worker's dependents, for an additional premium.

Fifth, there has been issued a coverage for doctor's treatments in the hospital, his office or the patient's home, usually eliminating the first three treatments. A stated amount, say, \$2 each for hospital and office calls, and \$3 each for home calls, is paid up to \$75, or some other stated limit, for any one condition. . . .

Attending physicians tell us that, after the first three calls, for which the patient pays without reimbursement, there is a decided tendency on the part of many to continue calling at the doctor's office, or even calling the doctor to the patient's home, long after there is any necessity for treatment. This spells unanticipated additional claim dollar cost.

Then, here's a problem with controversial possibilities. Before the coverage was effective, John Smith had a cold. His doctor medicated his nose and throat, gave him some pills and told him to go home and stay in bed a day or two, and drink a lot of water. It all worked out fine. John went back to work. Both he and the doctor forgot all about it. But now, John has bought this new coverage. He has a cold. What happens? The same thing, except the doctor now tells John that just as soon as his cold symptoms subside, he should take a series of cold shots. John gets them free. The doctor says it is good medical practice, now made possible by this insurance cover. So, many common colds which were not supposed to participate in the distribution of these funds to any great extent, cost more claim dollars than anticipated. Similar situations develop in the treatment of other conditions—directly attributable to the insurance reimbursement for treatments. Please understand there is no thought of criticism involved in our presenting this illustration. Preventive treatment is exclusively within the medical province. It is just another factor to correct the thought of those who assume that the cost of the doctors' calls and treatments would be the same if covered by any plan as the cost is now, without such coverage. Also, it is yet to be decided whether it is an essential part of the medical, surgical, hospital and indemnity coverage plans so widely discussed. It may well be that the average American worker is not interested in coverage for ordinary medical expense. Recent polls of workmen's opinion so indicate. . . .

The hospital and surgical covers are much easier to handle in claims. The increasing cost is due chiefly to two factors. When it is first placed, those who have been postponing minor surgical procedures, sometimes major ones, sign up immediately and then have those operations. In general, a more favorable claim experience may be

anticipated if practically 100 per cent of the group take the coverage.

Second, there is a marked tendency for the doctors and the hospitals to use hospital facilities in minor surgical cases where this type of coverage is in effect, and for longer periods than was the case before the coverage became so widespread, if the hospital is not too crowded or short-handed. Especially do we find this so where, as in some policies, the surgeon's fee is payable only for those procedures done in the hospital.

At this point in our discussion let us consider the present necessity for limitations in coverage. An insurance company can cover almost any contingency which can be anticipated in advance—for a premium which will cover the claim payments, the cost of administering the cover and a small margin of profit. It is really no more than a conduit into which flow the stipulated contributions of the worker and of the employer, and out of which flow the benefits to those who need them. The coverages should be fitted as nearly as possible to the needs of the worker. Competing companies estimate the premium necessary and submit their proposals. The loss experience of the group thereafter determines whether the premium was too high. If so, an adjustment is made. If the losses exceed the premiums, the employees and the employer must chip in more money to continue the coverage. If the additional premium necessary for renewal of the policy becomes too great, it can and probably will be dropped and the workers left without the protection. All workers, doctors and hospitals who realize how much benefit the coverage is to them and to each other must share the responsibility for its continuance and enlargement.

The amounts up to which reimbursement of surgeons' fees will be paid for surgical procedures are covered for the most part in the printed schedule in the policy. For those not appearing in the schedule, a proportionate amount is set by the company in each instance. The maximum for all procedures in one claim is usually \$150. The amounts stated in the schedule and the amounts allowed for procedures not in the schedule are in no sense an estimate of what the surgeon should charge or an evaluation of his services.

The weekly indemnity for total disability due to injury or illness presents more complicated problems and requires the greatest degree of cooperation by all concerned. We need not dwell upon its obvious economic, healthful, morale sustaining benefit, when properly administered. . . .

In order that you may know our comments indicating abuse of the weekly indemnity are not just impressions or theoretical, one company recently investigated 140 run-of-the-mill pending group weekly indemnity claims in one war plant. Forty of the claims were closed immediately upon the findings. Thirty-four other claimants were not at home, or in the hospital, when the investigator called. Sixty-six (less than half of the total) were found to be genuinely disabled.

It is interesting to note at this point some figures released by the Rhode Island state-administered sick benefit plan. Out of 6,000 claimants ordered to appear for examinations before board physicians in support of their claims for sickness benefits, more than 1,400 (or nearly one-quarter) failed to put in an appearance at all and thus automatically put an end to their claims. Of the remainder, about 1,650 persons were denied benefits after examination by board physicians, slightly more than 2,700 had their claims approved, and 205 others were requested to submit to laboratory tests.

These highlights of the coverage and some of the problems involved in the claim administration of them have been offered as a basis of more complete under-

standing of what it is you and we are trying to do, and how we may improve the performance of our respective responsibilities in the program. . . .

We have already indicated that in our opinion voluntary group insurance is not the whole answer to the current discussion of medical care. No matter how perfect our administration of the plan becomes, it will have to be supplemented by such plans as the Blue Cross and other hospital plans, by medical care plans sponsored by medical associations or other groups of doctors by continually improved workmen's compensation laws and by the necessarily tax supported local, state and government plans for the care of the indigent, and by the continuation and improvement of the preventive work in tuberculosis and other fields. And, of course, there are millions of individual policies in force covering accident, sickness, hospital and surgical care. We think it important that such a perspective be constantly in mind and we suggest that proponents of the various other plans often lose this perspective in urging some one plan as the cure-all. Such over estimates only serve to give the public a confused, kaleidoscopic set of impressions which make it difficult to gain public support for a properly balanced set of plans supplementing each other in solution of this complicated problem in its entirety. . . .

In conclusion, we are convinced that the medical profession and the group insurance claim men should, as soon as practical, combine their experience, ability and efforts to solve the problems and to achieve the goals we have tried to point out to you in this discussion. We submit that the first step in this procedure is to acquaint the doctors of the country with these problems and our mutual goal. This, in turn, we are told, can best be done through the County Medical Societies, with each State Medical Association guiding the program to the County organizations. If you feel that this discussion gives an insight into the problems of group claim administration and will be helpful to the medical profession, the International Claim Association will endeavor to provide speakers in response to invitations from the County or other local Medical Societies, or Associations. . . .

#### ITEM IX

##### Some Comments on the British Panel System

In its issue of May 12, 1945, the publication "*The New Statesman*" prints a letter from a correspondent under the caption "Public Health and Vested Interests."

From this letter the following excerpts have been taken:

"It is a little over a year ago that the White Paper on a National Health Service appeared. Mr. Willink has now consulted the doctors, the voluntary hospitals and the local authorities, as he said he would do, and a much modified scheme has been produced. This new scheme is tentative, incomplete in many details, and supposed to be "confidential," though it has been sent by the British Medical Association to 70,000 doctors for their observations. . . .

"No more retrograde step could possibly be conceived than the extension to the whole population of the type of service provided under the National Health Insurance Act. The people know something of the panel, because they have suffered from it. They expect something better and will see that they get it. But it is not only that the panel is unpopular. Although many of its doctors do their best for their patients, there is little to encourage them to do so. In the first place it is solely a disease service. There is no thought of the maintenance of health or prevention of ill-health about it, and the panel doctor has no contacts or association with the preventive services. It is only when the patient feels himself unwell—



usually too ill to carry on—that he seeks advice, and then the doctor's business is solely to rid him of his present trouble, which too often means merely relieving him of immediate and unpleasant symptoms.

"Worse still, the continuance and extension of the panel means the continuance of two types of patient—the private, who enter by the front door and are seen at once, and the public, who come in at the back and have to wait long periods. And two types of patient mean two types of treatment." . . .

#### ITEM X

### A Layman Looks at Health Insurance in New Zealand\*

*An Article by Shirley Jenkins, from Far Eastern Survey, of April 11, 1945*

With numerous socialization plans cropping up in our country, it is of interest to evaluate such experiments in operation in other countries. New Zealand set up a vast socialization program before the war and the operation of such a program which includes medical care is of interest to us.

New Zealand's expenditures on social security practically bankrupted the country, exhausting its credit, and wealth was practically taxed to oblivion. The forty-four hour week was replaced with a fifty-four hour week and the ranks of the unemployed were increasingly great.

At present the doctors' paper work has increased ten-fold, encroaching on proper medical diagnosis and treatment; a sheaf of certificates is required for various benefits which greatly hamper any medical effort. The following article written by a layman presents data on the New Zealand experiences that are enlightening.—*"Bulletin of the San Francisco County Medical Society."*

\* \* \*

The vital statistics of countries in the Pacific region reveal extremes of living conditions. For example, the average life expectancy in India is 27 years; in New Zealand it is 67. These are not unexplainable or accidental figures. New Zealand has a high average standard of living as well as exceptionally favorable climatic conditions. In addition, the country has pioneered in providing for the health of its people. The extension of medical and hospital benefits in recent years represents a new and experimental development in the long history of social legislation in the Dominion. Many difficulties were faced in making this plan effective, and a knowledge of the problems met and the resistances overcome may be of interest to persons anxious to see the extension of similar benefits in other countries.

The New Zealand Social Security Act of 1938, an important measure of the Labor Government, coordinated and extended existing provisions for old-age and unemployment insurance, benefits to widows and orphans, family, invalid and sickness benefits, and introduced provisions for various types of health insurance.

The intent of the framers of the Act was to inaugurate a comprehensive plan for medical care, a program that would provide treatment, as well as diagnosis; medicine, as well as prescription. According to the Act, every person in the Dominion was entitled to free medical treatment by a general practitioner, prescribed medicines, drugs and appliances, free care in public hospitals, full maternity care including ante- and post-natal treatment, and other supplementary benefits which may be introduced from time to time. No means test was contemplated,

and the plan was flexible enough so that persons who desire to use private hospitals may do so by making an additional payment.

The plan for free treatment in hospitals was comparatively easy to introduce, as it was superimposed on a network of existing public hospitals, serving the majority of the population. Before the Social Security Act went into operation, these hospitals were financed by government subsidies, local contributions, and payments of patients' fees. The new legislation, which went into effect in 1939, provided for payment from the Social Security Fund of patients' fees, at the rate of 6s. a day, later raised to 9s. If a patient chooses to go to a private hospital which charges higher rates, the 9s. a day from the Fund will be accepted as part payment. Public hospitals also provide free out-patient care, with 60 per cent of the costs of both salaries and materials coming from the Social Security Fund, the balance from other public funds.

The cost of free hospital care to the Fund has almost doubled in the past five years, rising from £1,258,633 in 1940-41 to £2,165,408 in 1943-44. The principal items are:

#### HOSPITAL CARE, 1943-44

Treatment in public hospitals.....	£1,571,192
Out-patient treatment .....	73,138
Treatment in public hospitals and approved institutions .....	283,065
Mental hospitals .....	182,829
Other institutions .....	55,184
<b>TOTAL .....</b>	<b>£2,165,408</b>

The large increase in expenditure is due primarily to a liberalization of existing provisions, and the introduction of new forms of treatment, as well as an increased load on the existing facilities. For example, out-patient treatment was introduced on March 1, 1941. Included in the hospital plan is medical and surgical care, laboratory and x-ray examination, all drugs, as well as maintenance and nursing care. There is no limit to the length of the stay.

Although a plan for free medical treatment was written in the law, this scheme remained largely ineffective for several years. *Neither appeal nor coercion on the part of the government produced the desired effect: 90 per cent of the family doctors were unwilling to cooperate.* The original plan for medical benefits in the 1938 Act is a capitation system whereby the doctor would receive a blanket payment from the Fund of 15s. a year for every person registered with him. There is freedom of choice for both doctor and patient. An individual, requiring benefits, simply indicates on an application form the name of the doctor he prefers and forwards it to the District Medical Office of Health. If the doctor agrees, the applicant is then registered on his list, and he is obliged to provide him with suitable medical care, both in the office, and, if necessary, in the home. If for any reason the patient is dissatisfied, he is perfectly free to change physicians and the doctor has a corresponding privilege.

#### Medical Association Protests

When the government made a determined effort to get the plan going early in 1941, it met strong opposition from the medical profession. The president of the National Medical Association, Dr. James P. Jamieson, assailed the plan and called it State helotry, and the *New Zealand Medical Journal* charged that the plan would make doctors State servants, without working hours, vacations, promotions, or pension. In answer, the *Standard*, organ of the Labor Party, charged the Medical Association as standing as a power above Parliament, maintaining medicine on a profit-making basis rather than as a service to humanity. But all the charges and name-calling

\* Letters concerning the German Krankenkassen and English Panel systems have appeared in previous issues of CALIFORNIA AND WESTERN MEDICINE. (In April C. & W. M., British, p. 195; Krankenkassen, page 196; and in May, Russian, page 285.)

came to nothing: *the doctors stood firm*. Press reports indicate that less than one per cent of the doctors responded in the early weeks of the campaign.

Aside from the general arguments for and against social medicine, or a health insurance plan, there were many practical problems to be worked out. For example, some persons have charged that coöperating doctors included some of the least competent. This was because they could be assured a minimum income if enough patients would register with them. Furthermore, the doctors complained that if committed to this scheme they could not discriminate among patients on medical grounds but would have to devote time to all comers, whether they regarded them as ill or not. Since the same fee was paid regardless of the number of times the doctor saw a patient, there is the possibility of discrimination against patients who are chronically ill in favor of patients with a good health record.

Behind all these reasons was another factor, which contributed greatly to the failure of the plan. This was the economic position of the doctors in New Zealand in 1941. In that year the patient-doctor ratio, never very low, became very high. By June, 1941, 3 per cent of the country's doctors had already been casualties or prisoners of war. The shortage of doctors was so acute that by January, 1944, 352 of the country's 1,200 registered physicians were mobilized, and one region in the country with a population of 40,000 had a single physician.

Compromise Plan

In Setem্বর, 1941, the seven months' deadlock between the doctors and the government was broken by the introduction of a *new bill providing for a "fee for service" plan*. This was an alternative to the capitation scheme, which was still to remain in effect. The new plan is called general medical services, to distinguish it from the old plan, called medical benefits. Under the new scheme a fee is paid to the doctor from the Social Security Fund of 7/6 for a consultation or home visit, 12/6 for Sunday and night calls, and a higher fee if the service involves more than 30 minutes of the doctor's time. As in the capitation plan, some traveling expenses are permitted. The doctor may claim the fee from the Fund, or from the patient, in which case the latter obtains a refund from the Fund. However, *the doctor is not obligated to accept the fee as full payment for his services*, although he cannot recover any charge over the fee by legal process.

This plan was approved by practically all doctors, and the extent to which it was accepted may be seen from the following figures:

EXPENDITURE FOR MEDICAL NEEDS, 1943-44

General Medical Services (Fee for service) .....	£1,206,449
Medical benefits (Capitation scheme).....	55,612
Special Arrangements (including salaried doctors in isolated areas).....	32,669
Mileage fees under both schemes.....	60,391
TOTAL .....	£1,175,121

By May of 1944, 96 per cent of the doctors in New Zealand were coöperating to some extent with the Health Insurance program, and 22 per cent were coöperating fully, according to Mr. Walter Nash, Finance Minister. The difference is this: the doctors who coöperate fully send in their accounts of patients treated once a month to the Health Department for payment, or collect the stated 7/6 from the patients. The other doctors, the majority, accept the stipulated fee in part payment only, and then receive an additional sum from the patients. It is obvious how the shortage of doctors would tend to aggravate such a situation. However, the willingness of almost

all the doctors to coöperate to some extent with the Health Department indicates that a health insurance scheme is workable, even though it may in its inception face almost unanimous opposition from the medical profession. The end of the war, the return of the doctors, and the gradual realization by the people that medical care constitutes part of their social security program, all point to further acceptance of the scheme.

As indicated, the two major types of care in any health program are hospital care and general medical care. However, there are certain other specialized benefits which round out a program and make it really adequate. Perhaps the most important special type is maternity care. This plan, initiated in New Zealand in 1939, provided a good beginning for coöperation between doctor and Health Department, and its success contributed to the later participation of the physicians in the general medical benefits scheme. Under the plan a fee of £5/5/0, which had been agreed upon by the Minister of Health and the Council of the New Zealand Branch of the British Medical Association, was paid from the Fund to private physicians undertaking to give pre-natal, confinement, and post-natal care. In addition, care in maternity hospitals is provided, with benefits at the rate of £2/5/0 for the day or days of labor and of 12/6 a day for the fourteen days of subsequent hospital care. If a baby is born at home, a fee is allowed for an obstetric nurse, and for a visiting nurse. For the year 1943-44 the expenditure of maternity benefits totaled £513,938.

MATERNITY BENEFITS, 1943-44

Public and private hospital fees.....	£334,639
Medical practitioners fees.....	167,272
Obstetric nurses fees.....	12,027
Total .....	£513,938

Two other types of benefits already in effect are pharmaceutical benefits and x-ray diagnostic benefits. It is hoped that dental benefits will soon get under way. In addition the government is planning to establish health clinics in regions where groups of doctors are willing to perform such services, on a salaried basis.

A plan to provide housewives with domestic assistance has recently been announced. Financial circumstances of householders will determine whether the government will pay all or part of helpers' wages. Homes to benefit will be those with one or more children under twelve years where the mother is incapacitated, those with three or more children where any member requires general care, and those where all members are partly or wholly incapacitated. The plan will be financed by the government but will be administered by approved women's organizations

Integrated Social Security Plan

The health insurance plan described above, although administered by the Minister of Health, is an integrated part of the Social Security program, and is financed from the social security contributions. Because of this, it is difficult to make any comments on the comparative cost of the plan with others proposed in different countries. The contribution to the social security program, with all the benefits of health, old-age, unemployment insurance, et cetera, is one shilling on the pound (5 per cent) of income, both private and corporation income, plus an annual registration fee. This amounts to 5s. per quarter for men over 20, and 5s. per year for all others.

Although it is working well, the New Zealand plan, like any new and experimental legislation, is still subject to a good deal of improvement. For example, the problem of meeting the high fees asked by specialists has not yet been solved. Many doctors in New Zealand, interested in seeing the extension of health facilities, have made sound and constructive suggestions. They



point out that medical services cannot be extended very far unless the facilities for training new doctors are also expanded. In addition, new forms of treatment must be based upon heavily subsidized research programs. Inadequate attention, it is felt by some, has been given to preventive medicine.

New Zealand has one of the few comprehensive, working health insurance plans in the world. The last few years, however, have seen a new and widespread interest in social insurance, including medical care. Each of the other English-speaking powers, Australia, Canada, Great Britain, and the United States, has before it for consideration some such plan. That these schemes have developed in the midst of a bloody war, and when money incomes are high, may seem a paradox; however, it indicates that planning for a healthier society is a trend that will not be diverted, and that we are not likely ever to return to *laissez-faire*, horse and buggy medicine.—*Far Eastern Survey*, April 11, 1945.

#### ITEM XI

### England's System of Sickness Insurance

In the "*Bulletin*" of the Medical Society of the County of Kings, New York, recently appeared an interesting article by Major Clifford L. Graves, on the "Status of the English Doctor" under the health insurance systems operating in England.

The article is of special interest to California physicians because of pending legislation concerning sickness insurance. In connection therewith may be read the item which appeared in *CALIFORNIA AND WESTERN MEDICINE*, for January, on page 48, "Concerning State Medicine in New Zealand."

For readers in the United States, it may be stated the shilling is worth about 20 cents and is written with a / sign. Thus, five shilling four pence is written 5/4. There are 12 pence to the shilling and 20 shillings to the pound.

This material was obtained from one of the general practitioners in Kidderminster, a city with a prewar population of 30,000 which has now risen to 60,000. He is a man who has practiced "panel medicine" for ten years and has made a success of it, as far as that is possible. He has answered all questions frankly and analytically without trying to cover up the defects of the system.

This article will deal only with the practical aspects of the doctor-patient relationship and with the financial status of the doctor, rather than with the complicated and extensive administrative machinery that has come into existence. The object here is to outline how the average British citizen obtains medical care for himself and his family. For that reason, the information is presented in three parts:

I. The machinery to provide the wage-earner with ordinary general-practitioner's care. This is called National Health Insurance and is regulated by law.

II. The machinery to provide the same thing for his dependents. This is a private venture, undertaken by a group of doctors who organize a "Public Medical Society" for the purpose. Financial arrangements vary somewhat according to the charter of this society.

III. The machinery to provide consultant's services and hospitalization for both the wage-earner and his family. This is undertaken by the "voluntary hospitals" which are run by the city or county and supported by small subscriptions from those who wish to have a hospital insurance.

#### I. National Health Insurance

National Health Insurance has existed in England since about 1911 when it was passed under the sponsorship of the then Premier Lloyd George. At first it met

with much opposition from the medical profession and there were many doctors who refused to take on a panel. Wherever the system threatened to fail because of this the government placed young medical graduates in the recalcitrant locality. This was not difficult because in England a doctor must buy a practice when he starts and there were plenty of young men who here saw a chance to acquire a practice (even though it was only a panel practice) without having to pay the usual sum of 3,000 to 10,000 pounds for it. Since then health insurance has been accepted by the vast majority of doctors as an inevitable institution. In Kidderminster of a total of 13 doctors 11 practice panel medicine.

National Health Insurance will be discussed under the following headings:

- (1) What people are insured
- (2) What service is provided
- (3) Financial arrangements
- (4) The "Approved Society"
- (5) The status of the doctor:
  - (a) Financially
  - (b) Professionally

#### (1) WHAT PEOPLE ARE INSURED

The scheme includes every wage-earner, male or female, married or single, between the ages of 14 and 64, with an income of less than 420 pounds a year (until the war this figure was 250 pounds). The fees are deducted automatically from the pay check so that the system may be said to be compulsory.

When the wage-earner is temporarily unemployed, the state continues the payments for him, *provided he is on the dole*.

When the wage-earner reaches the age of 64, he stops paying all fees, becomes entitled to the old-age pension, and remains insured for the rest of his life.

When he stops paying before the age of 64 (this would be impossible with people getting regular paychecks because the deductions are automatic), he remains insured for two years after his delinquency.

People whose income is not paid in the form of a wage, such as shopkeepers, farmers and small pensioners, may make their payments quarterly. They do come within the provisions of the law, as long as their income is less than 420 pounds.

The 420 pounds limit means that well over 90 per cent of the population of England is included.

#### (2) WHAT SERVICE IS PROVIDED

This includes ordinary physician's care, office as well as house calls. No surgery except the most pedestrian kind, such as lancing a boil. The scheme also allows for some drugs, but only the less expensive ones. For those who belong to an "Approved Society" (see below,) it is sometimes possible to get spectacles, dental and surgical appliances free of charge.

#### (3) FINANCIAL ARRANGEMENTS

Payments are made by the week or month. They are divided equally between the employee and the employer, with the employer paying the odd penny if there is one. The total weekly contribution for individuals of 18 and over is one shilling seven pence (1/7) of which the employer pays ten and the employee nine. For an additional 3 pence (1/3), it is possible to secure a very small "sickness benefit," that is an allowance during illness, but it does not amount to more than 10/ a week and only for a limited time. The 1/3 is paid by the employee. Shopkeepers, farmers, pensioners, etc., pay 1/5 a week, *all themselves*. The money is collected automatically by pay-check deduction and a 1/7 stamp is pasted in a special card that is provided for this purpose. The stamps are bought at the post office.

Thus, the fund collects 52 times 1/7 or about 82/ a year. This is apportioned as follows:

For the doctor.....10/6 or 12.5 per cent  
 For drugs ..... 3/ or 3.5 per cent  
 For mileage fees at the rate of a  
 shilling per mile per year.... /6 or .5 per cent  
 For administrative overhead....68/ or 84.0 per cent

Attention is called to the disproportion of what the doctor gets and what the state collects. Up until 1939, the Fund had accumulated a surplus of 144 million pounds!

#### (4) THE "APPROVED SOCIETY"

This is a sort of private insurance company, organized to help administer the scheme and give certain extra advantages to the "good risks." Only those wage-earners who make separate application and who can pass a physical examination are accepted (the National Health Insurance Act itself makes no mention of a physical). The chief object of the approved society is to provide "sickness benefits," that is, small weekly payments to those who are ill and cut off from their regular source of income. It has already been pointed out that for an additional /3 a week the insured person may get a government sickness benefit but the payments are small (not more than 10/ a week) and last as long as there is a cash balance in his particular account.

The approved society on the other hand, is authorized to collect 4/10 out of the 82 shillings that is taken in for each individual who is a member. For this, it gives:

(a) A sickness benefit of from 18/ to 25/ a week, which is paid as long as the illness lasts. The variation of 18 to 25 depends on the society. The better ones pay the larger amount;

(b) "Grants-in-aid," that is, spectacles, dental appliances and surgical appliances, but only in limited amounts. A certain sum is set aside at the beginning of each year and when this is exhausted, no further grants can be made until the next year. Usually, the fund is used up long before the year is out.

The people who cannot belong to an approved society because of some disqualifying physical defect such as hypertension, diabetes, etc., are called deposit-contributors. It is optional with them if they want to belong and pay the extra /3 a week.

#### (5) THE STATUS OF THE DOCTOR

(a) *Financially.* A successful, busy practitioner can handle a panel of 2,000. Upper limit, fixed by law, is 2,500. A panel of 2,000 yields a yearly income of somewhat over 1,000 pounds. This may be increased slightly by the "certificates of disability" which the doctor writes for those whose illness compels them to stay away from work. Such a certificate costs the patient one shilling. Since 95 per cent of the cases are ambulatory, the profits on this score are small.

In Kidderminster, with a panel of 2,000, the doctor sees an average of 30 patients a day or 9,000 a year, so that his pay per office or house call is 2 shillings.

(b) *Professionally* the doctor's position is not a happy one for the following reasons:

Inspectors come around regularly to inspect his records. If these fail to pass, the doctor is fined without further process of law anything from 100 to 200 pounds. If a patient is disgruntled, he can report the doctor and the doctor is then investigated by a board, made up partly of laymen, partly of doctors. Again, the penalty is in the form of a fine, although this sort of trouble is usually squelched before it reaches a board. The fact remains, however, that a crackpot patient can cause the doctors no end of unpleasantness.

More irritating is the limitation in the allowance for drugs. Only certain inexpensive items may be prescribed. When two doctors in London, unaware of this, ran a large-scale scientific experiment on their aged patients by giving them large doses of codliver oil and malt ex-

tract (the doctors acted in good faith and accumulated valuable data), they were fined 1,000 pounds. This raised such a furor that the affair was investigated in Parliament. Regrettably, Parliament had to agree with the verdict because it was within the purview of the law.

Further, there is the limitation of what the doctor may do for his patient. The law says he may do only what is commonly considered to be within the province of the general practitioner. This definition has been tested repeatedly in court and has been very narrowly interpreted. For instance, a doctor may not inject hemorrhoids, give diathermy, remove polyps, or electrocoagulate warts. In fact, about the only thing he *can* do is to prescribe some inferior drug and he resorts to that abundantly. If the patient needs a consultant or an operation, he must be sent to the hospital (see below). The practitioner then loses track of his patient altogether, but a few with special training may apply for staff privileges. In Kidderminster, out of a total of 13 physicians, there are only two who may operate. These are paid a small fee when they operate on a panel patient. An appendectomy nets them one pound.

The average office call for a panel patient lasts three minutes: one minute to usher the patient in and out, one minute for the questioning and examination, and one minute for the writing of the prescription and the record. Since the doctor also sees many "club patients" (see below), his average daily quota of patients is from 60 to 70, about three-quarters office work and one-quarter home calls. His day lasts from 9 in the morning till 8 in the evening. He takes one afternoon a week off, plus his Sunday, and a two- to three-weeks' vacation every year.

#### II. The Public Medical Society

To provide the wage-earner's dependents with this same sort of care, doctors organize locally what is called a Public Medical Society or "club." They hire an accountant, collectors, and typists for the bookkeeping and take on a certain number of people on a sort of private panel. The average number per doctor is 1,000. The cost is /4 (4 pence) per week per individual up to a maximum of 1/4 for a single family. After that there is no further increase, so that very large families are not unduly penalized. The distribution of the profits is very interesting when compared with those of the National Health Insurance. It is as follows:

For the accountant..... 7.5 per cent  
 For the collectors.....12.5 per cent  
 For the doctors.....80.0 per cent

The main lesson to be learned here is that when the state operates the system, the doctors get 12.5 per cent, but when the doctors themselves operate the system, they get 80 per cent!

By having 1,000 "club patients," a practitioner can further increase his income about 660 pounds a year. The subscribers are, of course, mainly women and children. Although they represent only half the size of the regular panel, they account for fully as many office calls, an average of 30 a day. Add to this 30 panel patients and the total becomes 60. A very ambitious man such as the one interviewed also sees about 10 private patients a day, who add some 400 to 500 pounds a year to his income. Consequently his total income is about 2,000 pounds a year, which is not bad even at home, but it must be remembered that he is now at the top of the heap as far as panel practice is concerned.

#### III. The Voluntary Hospital Contributory Scheme

To provide hospital care for the wage-earner and his family there is still another scheme. It is operated by the hospitals themselves, as far as they wish to, and most of them do. A voluntary hospital exists from two sources, each one of about equal size:



- (1) Private donations and charity drives.
- (2) Small subscriptions by individual workers.

The fee for one wage-earner and his family is 4 pence a week, to which the employer adds one penny, making a total of 5. There is no compulsion about it as there is about National Health Insurance. The 5 pence a week yields 21/4 a year. The Kidderminster Hospital collected 18,000 pounds this way last year, about half its total operating cost. By being a "voluntary contributor," the wage-earner insures hospitalization for himself and his family for no matter what ailment or what operation, chronics excepted.

The hospital in Kidderminster has a staff with one specialist for each of the important departments, such as surgery, medicine, x-ray, laboratory, etc. None of these get paid, except for the surgeon, who gets 100 pounds a year for being the head of the OPD. The radiologist gets no salary, but has the privilege of using the department for his private patients. Consultants who must come from distant cities get a mileage fee of 100 pounds a year.

Obstetrics, which is usually a large source of income for the general practitioner at home, is not so in England because 95 per cent of the work on indigent patients is done by midwives. Doctors are called in only when there are complications. The scheme is administered by the county, which pays the doctor 2/6 for each pre-natal office call and 5/ for a house call. If the doctor does the delivery himself he collects three guineas and his anesthetist one guinea. This is paid by the county after an investigator has certified that the patient cannot pay. If the patient *can* pay something, the doctor gets a corresponding fraction of his three guineas. Even in the very active practice of our informant, however, obstetrics played a very minor part.

### Disadvantages of Socialized Medicine in England

The chief disadvantages of panel practice appear to be from this superficial survey:

- (1) The impossibility of doing good work because of the volume of work.
- (2) The restrictions in what the doctor can do for his patient in the office.
- (3) The discrepancy between the 10/6 for the doctor and the 68/ for the overhead.

### ITEM XII

#### Re: House Resolution No. 295

This resolution was submitted to the California Assembly, as recorded in the *Assembly Journal* of June 13, 1945, on page 54. (Resolution was adopted.)

Excerpt follows:

#### RESOLUTIONS

The following resolution by Mr. Crichton was offered:  
(For editorial comment, see page 1.)

#### HOUSE RESOLUTION No. 295

*Relative to the creation of the Assembly Health Care Investigating Interim Committee*

WHEREAS, The health of the people of the State of California is a matter of continuing concern to the Legislature; and

WHEREAS, There has been presented at this Fifty-sixth Regular Session of the Legislature numerous measures relating to making the health, medical, hospital and other care of the people of the State, including the raising of revenues to provide such care, a function of the State Government; and

WHEREAS, The Legislature is in need of further information as to the need for the care to be provided, the types of care to be provided, the classes of persons for whom the care should be provided, the administration of the care, the cost of the care, and the existing and possible sources of revenue which may be used to provide the care; now, therefore, be it

Resolved by the Assembly of the State of California, As follows:

1. The Assembly Health Care Investigating Interim Committee is hereby created and appointed and authorized and directed to ascertain, study and analyze all facts relating to the health of the people of the State of California,

the adequacy of existing sources to maintain and improve the health of the people,

any additional means for maintaining and improving the health of the people,

the need for the provision of health care for the people, or any classes thereof, by the State Government or any agency thereof, the cost of providing for health care by the State Government or any agency thereof,

and the existing and possible sources of revenue which may be used to provide such care, including but not limited to the operation, effect, administration, enforcement and needed revision of any and all laws in any way bearing upon or relating to the subject of this resolution, and to report thereon to the Assembly at any regular or special session, including in the reports its recommendations for appropriate legislation.

2. The committee shall consist of seven Members of the Assembly appointed by the Speaker thereof. The chairman shall be selected, and vacancies occurring or existing in the membership of the committee shall be filled by the Speaker.

3. The committee is authorized to act during this session of the Legislature, including any recess, and after final adjournment until the commencement of the next regular session, with authority to file its final report not later than the fifteenth legislative day of the next regular session.

4. The committee and its members shall have and exercise all of the rights, duties and powers conferred upon Investigating Committees and their members by the provisions of the Joint Rules of the Senate and Assembly and of the Standing Rules of the Assembly as they are adopted and amended from time to time, which provisions are incorporated herein and made applicable to this committee and its members.

5. The committee has the following additional powers and duties:

(a) To cooperate with and secure the cooperation of county, city, and county, and other local law enforcement agencies in investigating any matter within the scope of this resolution and to direct the sheriff of any county to serve subpoenas, orders and other process issued by the committee.

(b) To report its findings and recommendations to the Legislature and to the people from time to time and at any time, not later than herein provided.

(c) To do any and all other things necessary or convenient to enable it fully and adequately to exercise its powers, perform its duties, and accomplish the objects and purposes of this resolution.

(d) To meet at the State Capitol, or at any other place within this State or within the United States.

6. The sum of fifty thousand dollars (\$50,000) or so much thereof as may be necessary is hereby made available from the Contingent Fund of the Assembly for the expenses of the committee and its members and for any charges, expenses or claims it may incur under this resolution, to be paid from the said Contingent Fund of the Assembly and disbursed, after certification by the chairman of the committee, upon warrants drawn by the State Controller upon the State Treasurer.

Resolution read, and referred to Committee on Rules.

*Ewart's Sign.*—The association of William Ewart with St. George's Hospital, beginning with his studies in the medical school in 1869, was both long and fruitful. During the seven years in which he was an assistant physician in this hospital, he spent much of his time in out-patient practice. There was nothing stereotyped about his clinical teaching; he was on occasion brief or diffuse, rapid or lengthy in discussion. His most important literary work was entitled "Pulmonary Cavities."—*Warner's Calendar of Medical History.*

(References to article, "Abscess of the Tongue.")

Concluded from Page 13

13. Salinger, Samuel, Abscess of the Tongue, *Annals of Otolaryngology, Rhinology, and Laryngology*, vol. 50, pages 573-574, (June), 1941.

14. Gerwig, W. H., Jr., and Dick, Arthur, Abscess of the Tongue, *The Military Surgeon*, vol. 91, pages 337-340 (Sept.), 1942.

15. McLaughlin, Charles W., Jr., and Davis, J. Calvin, Abscess of the Tongue, *American Journal of Surgery*, vol. 58, pages 133-136 (Oct.), 1942.

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

### On Letters of Appreciation to State Legislators:

Doctor H. A. Johnston, Councilor of C.M.A. District No. 1 recently sent the letter printed below to the secretaries of the Orange, San Bernardino, Riverside, San Diego and Imperial County Medical Societies.

The letter contained the names and addresses of the assemblymen from the above counties. The letter is printed here for its suggestive value.

(COPY)

Anaheim, California, June 8, 1945.

Dear Doctors:

I know you will be interested to learn that all the Assemblymen from District No. 1 of the California Medical Association voted against the withdrawal from the Committee of the Governor's compulsory hospital bill.

These men have stood shoulder to shoulder in protecting us from the Governor's insistence upon the socialization of medicine and hospitals in California. Where would we be today were it not for the help of these representatives? I think we should congratulate ourselves upon finding that the nine representatives from the Counties comprising District No. 1 all voted one way.

I believe we should telegraph or write these gentlemen our thanks immediately. Address your Assemblyman, care of the State Capitol at Sacramento. For your information I am giving you below a list of the Assemblymen representing the Counties comprising the First District.

Since most of the County Societies have no meetings after June, and the Assembly closes June 15th, I urge that this be taken care of immediately. If your Society does not have a meeting yet to be held in June, kindly get in touch with the different members of your Society by letter or phone.

We all consider this very important.

Sincerely yours,

(Signed) H. A. JOHNSTON, M.D.,  
Councilor, District No. 1,  
California Medical Association.

### California Senate Kills Legitimacy Bill

Sacramento, June 14.—California Senators today upheld the right of a service man to be notified of his wife's unfaithfulness.

The State Senate judiciary committee in effect killed a bill permitting the wife of a serviceman to give her illegitimate child away for adoption without telling her husband.

Assemblyman Gardiner Johnson (R., Berkeley), the author, said the idea behind the original bill was to protect the interests of illegitimate children. The bill was sponsored by the California Department of Social Welfare.

"I later agreed that a serviceman who wants to sue his wife for divorce on grounds of adultery should have his right protected," Assemblyman Johnson commented.

He requested the Senate committee to strike from his bill the provision that an illegitimate child of a serviceman's wife could be adopted without notifying the fighting man.—San Francisco News, June 14.

### S. 134: Re Physicians Needed for Military and Civilian Service

(COPY)

AMERICAN MEDICAL ASSOCIATION

Council on Medical Service and Public Relations

Washington, D. C., June 13, 1945.

On Tuesday, June 12th, Senator Downey of California, introduced the following resolution (S. Res. 134) which was referred to the Committee on Military Affairs. Senator Downey hears that there may not be an adequate number of physicians to meet the postwar needs and feels that steps should now be taken to meet the great demand that there may be. He considers this matter of such importance that he will press the Military Affairs Committee for immediate action on his resolution.

"Resolved, That the Committee on Military Affairs, or any duly authorized subcommittee thereof, is authorized and directed to make a full and complete investigation with respect to the relative needs of the armed forces and the civilian population for the services of medical personnel with a view to ascertaining (1) whether, as a result of developments in the war, or through more efficient utilization of medical personnel, such personnel can be released from the armed forces for civilian service without impairment of the war effort; (2) the speed with which demobilization of medical personnel in the armed forces can be accomplished as the needs of the armed forces diminish, and (3) whether any further action is necessary to insure an adequate supply of trained medical personnel to meet the future needs of the armed forces and the civilian population of the Nation. The committee shall report to the Senate at the earliest practicable date the results of its study and investigation, together with such recommendations as it may deem desirable.

"For the purposes of this resolution, the committee, or any duly authorized subcommittee thereof, is authorized to hold such hearings, to sit and act at such times and places during the sessions, recesses, and adjourned periods of the Seventy-ninth Congress, to employ such clerical and other assistants, to require by subpoena or otherwise the attendance of such witnesses, and the production of such correspondence, books, papers, and documents, to administer such oaths, to take such testimony, and to make such expenditures, as it deems advisable."

Very truly yours,

JOSEPH S. LAWRENCE, M.D.,  
Director, Washington Office,  
Council on Medical Service,  
1835 I St., N.W.

### Military Hospitals Suggested for Mineral Springs Areas of California\*

Senate Joint Resolution

No. 23

INTRODUCED BY SENATOR BIGGAR

May 18, 1945

(Adopted by California State Senate on May 25, 1945, and by State Assembly on June 12, 1945.)

*Senate Joint Resolution No. 23—Relative to memorializing the President and Congress of the United States and the Surgeon Generals of the United States Army and Navy to consider the advisability of, and the special advantages to be derived from, establishing one or more military hospitals in mineral spring areas of California, and urging that affirmative action be taken in regard thereto.*

WHEREAS, As World War II continues, it becomes increasingly evident that American casualties to soldiers and sailors will be in excess of one million; and

WHEREAS, Soldiers and sailors who have received wounds or have been otherwise physically or mentally disabled are being returned in increasing numbers to the United States for convalescent and rehabilitation treatment, to make possible their return to the armed forces or to civilian life; and

\* For editorial comment, see page 3.



WHEREAS, Medical experience, during many years, has demonstrated the great value of mineral spring or properly conducted spa treatment for patients suffering from nervous and other physical and mental disorders; and

WHEREAS, California possesses many areas easy of access, with climatic and environmental conditions of highest order, in which treatment procedures such as those carried on in Saratoga Springs in New York and in Hot Springs National Park in Arkansas could be easily established; and

WHEREAS, Additional governmental hospitals are still being authorized and erected by the military authorities; now, therefore, be it

*Resolved by the Senate and Assembly of the State of California, jointly, at this Fifty-seventh Regular Session of the Legislature, That the President and Congress of the United States and the Surgeon Generals of the United States Army and United States Navy are hereby respectfully memorialized to consider the advisability of, and the special advantages to be derived from, establishing one or more military hospitals in mineral spring areas in the State of California, where in healthful surroundings and with appropriate spa-structures and equipment, the convalescence, health and rehabilitation of large numbers of invalided soldiers and sailors could be more effectively promoted and their return to useful military or civilian life be more definitely assured; and be it further*

*Resolved, That as a result of such considerations, affirmative action be taken to accomplish the foregoing purposes; and be it further*

*Resolved, That the attention of the President and Congress of the United States and of the Surgeon Generals of the Army and Navy is hereby called and re-directed to Senate Joint Resolution No. 12, unanimously adopted by the Fifty-fifth California Legislature (Cal. Stats. 1943, Res. Ch. 52), on this same subject, copies of which resolution were transmitted to them upon its adoption; and be it further*

*Resolved, That the Chief Clerk of the Assembly is directed to transmit copies of this resolution, and of the Senate Joint Resolution of the Fifty-fifth Legislature hereunto annexed, to the President of the United States, the Surgeon Generals of the United States Army and the United States Navy, to the President pro tempore of the Senate of the United States, the Speaker of the House of Representatives of the United States, and to each Senator and Representative from California in the Congress of the United States; and that the Senators and Representatives from California be respectfully requested to urge such action.*

## President Truman Backs Wider Social Security Plan

*Senator Wagner to Ask Revamp With White House Support*

Washington, May 16.—Senator Robert F. Wagner, Democrat of New York, stated tonight that President Truman will send a series of messages to Congress soon recommending a sweeping expansion of the Social Security program.

The New Yorker, chairman of the Senate Banking and Currency Committee, disclosed also that he will introduce in the Senate next Thursday a bill proposing the changes which he said the President will recommend.

Congressional circles termed Wagner's proposed bill an American version of the British "birth-to-the-grave" Beveridge plan.

### Details Told

Wagner told International News Service that his bill would:

1. Increase the Social Security tax on employees and employers to 4 per cent each.
2. Provide medical and hospital care to all workers covered by Social Security, their wives and children under 18.
3. Raise unemployment compensation to a maximum of \$30.
4. Federalize unemployment compensation, now handled by the States.
5. Call on the Federal Government to contribute to the Social Security fund when financial help is needed.
6. Extend Social Security to an additional 15,000,000 persons—domestic and farm workers and self-employed.
7. Provide both temporary and total disability payments.
8. Make women eligible for old age pensions upon reaching 60 instead of 65.—*San Francisco Examiner*, May 17.

## COMMITTEE ON ORGANIZATION AND MEMBERSHIP

### Alameda County Medical Association Welcomes Its New Executive Secretary

The June "Bulletin" of the Alameda County Medical Association contains the following:

(copy)

#### *President's Message*

Our Executive Secretary, Mr. Rollen Waterson, has arrived and is becoming oriented. He met with the "Interim Committee" of the Council, which approved broad objectives, a list of definitions, and an ambitious "production schedule," thus laying down the foundation for his work—and ours—as we proceed to expand our horizons and to add to our organized effectiveness. You will hear from Mr. Waterson at the June meeting. Be sure to attend.

Most significant of his definitions, and, in his opinion the common denominator for all the rest, is Waterson's philosophy of public relations:

Public relations shall be a philosophy of the conduct of the affairs of the Alameda County Medical Association that interprets every act in terms of the ultimate *public interest*, and then tells the public what has been done.

Here, certainly, is bed-rock foundation upon which to build. This is what has been called "enlightened selfishness," for none can deny that our future influence and prosperity—our very freedom, in fact—will be determined, first, by how well we serve the public, and, second, by how well informed the public becomes regarding what we have done in the public interest.

We agree with Mr. Waterson that we must constantly recommit ourselves to the public interest. And, having so done, we may then embark upon the new ventures that are being planned for us with full confidence that success, mutual profit, effective organization, and an even deeper pride in our profession, will be the certain rewards for our efforts.

Welcome to Alameda County, Mr. Waterson! I am confident our members have both the intelligence and the courage to accept and apply this basic philosophy. Success to you, Waterson! And, thereby, success to us!

HARRY TEMPLETON, *President*.

### Radiology and Pathology in New York Blue Cross Groups

Congratulations and thanks are due the Hospital Association of New York State. Last fall the Association adopted a resolution to the effect that radiology and

pathology would be dropped from Blue Cross benefits when medical service plans were prepared to furnish these medical services among its benefits on a fee basis.

Last month the Association announced the following agreement with the Medical Society of the State of New York:

"(a) It is agreed that Pathology, Anesthesiology, Roentgenology and Physical Therapy are medical services and the practice of medicine.

"(b) That these specialties are so recognized.

"(c) That an equitable arrangement can be made between the individual hospitals and the doctors who practice these four specialties recognizing the above principle, whereby the hospital may bill for these services in the name of the person rendering the service. (This can be done by inserting the name on the regular hospital bill-head, i.e.: Instead of X-ray, indicate "Professional Services of Dr. ———, Roentgenologist.")

"(d) Until such time as a Medical Service Plan is available, there is no objection to inclusion of these medical services in the hospital service plan contract as long as the principle of recognition and proper remuneration to these specialists is carried out."—Monthly "News Letter," American College of Radiology.

## COMMITTEE ON POSTGRADUATE ACTIVITIES†

### Wartime Graduate Medical Meetings

Note.—The C.M.A. Postgraduate Committee presents below a roster of speakers and topics of "Wartime Graduate Medical Meetings." These listings may have suggestive value to program committees of Component County Societies.

#### CLINICS, DEMONSTRATIONS, LECTURES

Under the Auspices of the American Medical Association, the American College of Physicians, the American College of Surgeons

#### Committee 24th Zone

Lt. Comdr. Geo. C. Griffith (MC), USNR, Chairman  
U. S. Naval Hospital, Corona, California  
Capt. Harry P. Schenck (MC), USNR  
Wayland A. Morrison, M.D.  
James F. Churchill, M.D.

(Continued from Page 362, June C. and W. M.)

"*Internal Derangement of the Knee*"—Dr. John C. Wilson, Professor Orthopedic Surgery, University Southern California, Los Angeles.

U. S. Naval Hospital, San Diego, Thursday, June 7, at 1300

"*Diabetes*"—Dr. H. F. West of Los Angeles and Dr. J. W. Sherrill, of San Diego.

Birmingham General Hospital, Van Nuys, Wednesday, June 13, at 1500

"*Spondylitis*"—Major A. J. Present, Hoff General Hospital, Santa Barbara, Chief of Radiology.

U. S. Naval Hospital, Santa Margarita Ranch, Oceanside, Thursday, June 14, at 1300

"*Surgery of Traumatic Urinary Tract*"—Lt. Comdr. John B. Wear, U. S. Naval Hospital, San Diego.

U. S. Naval Hospital, Corona, Thursday, June 14, at 1300

"*Diabetes*"—Dr. H. F. West of Los Angeles and Dr. J. W. Sherrill of San Diego.

U. S. Naval Air Training Station, San Diego, Friday, June 15, at 1500

"*Dentistry*"—Comdr. E. P. Garvey (DC), U.S.N.H., San Diego.

March Field, Riverside, Tuesday, June 19, at 1530

"*Peritonscosp*"—Capt. J. C. Ruddock, Chief of Medical Service, U. S. Naval Hospital, San Diego.

Torney General Hospital, Palm Springs, Tuesday, June 19, at 1530

"*Tumor Pathology*"—Dr. Edward Butt of Los Angeles. A.A.F. Regional, Hospital, Santa Ana Army Air Base, Tuesday, June 19, at 1930

"*Differential Diagnosis of Hysteria*"—Dr. J. M. Nielson of Los Angeles.

U. S. Naval Hospital, Long Beach, Wednesday, June 20, at 1500

"*Aviation Medicine*"—Capt. L. E. Mueller, U. S. Naval Air Training Station, Medical Officer in Command, San Diego.

Station Hospital, Camp Cooke, Wednesday, June 20, at 1300

"*Cardiac Pain*"—Capt. A. R. Twiss of Santa Ana Army Air Base.

Hoff General Hospital, Santa Barbara, Wednesday, June 20, at 2000

"*Cardiac Pain*"—Capt. A. R. Twiss of Santa Ana Army Air Base.

Birmingham General Hospital, Van Nuys, Wednesday, June 27, at 1500

"*Burns*"—Capt. Harold L. D. Kirkham, U. S. Naval Hospital, San Diego.

U. S. Naval Hospital, Santa Margarita Ranch, Oceanside, Thursday, June 28, at 1300

"*Anesthesia in War Surgery*"—Lt. L. E. Trotter, U. S. Naval Hospital, San Diego.

U. S. Naval Hospital, Corona, Thursday, June 28, at 1300

"*Blood Bank and Allied Subjects*"—Lt. Comdr. W. M. Cashman, U. S. Naval Hospital, San Diego.

#### U. S. Naval Air Training Station, San Diego

June 1—RH Factor—Capt. George Macer (MC), A.A.F. Regional and Convalescent Hospital, Santa Ana.

June 15—Dentistry—Comdr. R. Garvey (MC), U.S.N.R., U. S. Naval Hospital, San Diego, California.

A.A.F. Regional and Convalescent Hospital—Santa Ana Army Air Base

June 5—Plastic Surgery in Defects of Head and Neck. In connection with colored surgical moving pictures—Dr. Edward Lamont.

June 19—Differential Diagnosis of Hysterias—Dr. John Neilson.

#### U. S. Naval Hospital—San Diego

June 7—Management of the Diabetic Patient—Dr. James Sherrill, Scripps Metabolic Clinic, La Jolla, California. (Meetings at the Torney General Hospital, Palm Springs, have been discontinued during the summer months due to the excessive heat. They will recommence September 15th.)

#### U. S. Naval Hospital—Santa Margarita Ranch, Oceanside, California

June 14—Injuries of the Ureter—Lt. Comdr. C. P. Rusche (MC), U.S.N.R., U. S. Naval Hospital, San Diego.

June 28—Selection of Proper Agent and Method in War Anesthesia—Lt. L. E. Trotter (MC), U.S.N.R., U. S. Naval Hospital, San Diego.



- Birmingham General Hospital, Van Nuys, California*  
 June 13—Spondylitis—Major Arthur J. Present (MC),  
 Hoff General Hospital, Santa Barbara.
- June 27—Observations on the Management of Burns and  
 Their Plastic Repair—Capt. Harold L. D. Kirkham  
 (MC), U.S.N., U. S. Naval Hospital, San Diego.
- A.A.F. Regional Hospital—March Field, Riverside,  
 California*
- June 19—Peritoneoscopy—Capt. J. C. Ruddock (MC),  
 U.S.N.R., U. S. Naval Hospital, San Diego.
- Station Hospital—Camp Haan, Riverside, California*
- June 5—Thoracic Surgery—Lt. Comdr. J. E. Dailey  
 (MC), U.S.N.R., Dr. John Jones.
- U. S. Naval Hospital—Long Beach, California*
- June 20—Pathogenesis of Rheumatic Fever—Lt Comdr.  
 Robt. W. Huntington (MC), U.S.N.R., U. S. Naval  
 Hospital, Corona.
- U. S. Naval Hospital—Corona, California*
- June 14—Progress in Diabetes—Dr. Howard West.
- June 28—Surgical Conditions of the Liver and Its Ducts  
 —Capt. E. E. Larson (MC), U.S.N.R., U. S. Naval  
 Hospital, San Diego.
- Station Hospital—Camp Cooke, Lompoc, California*
- June 20—Cardiac Plan—Capt. Arthur Twiss (MC),  
 A.A.F. Regional and Convalescent Hospital, Santa  
 Ana.
- Hoff General Hospital—Santa Barbara*
- June 6—Internal Derangements of the Knee—Dr. John  
 Wilson.
- June 20—Cardiac Pain—Capt. Arthur Twiss (MC).

## C.M.A. CANCER COMMISSION

### REPORT OF THE COMMITTEE ON CANCER CONTROL OF THE WOMEN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

This year, the fight against cancer has been more than encouraging. Like a pebble rolled from the top of a mountain, that gathers force and becomes an avalanche, so this noble work has gathered strength. Last year during April, 1944, \$750,000 was raised by the American Cancer Society. A minimum of not less than 5 million dollars has been set for 1945, to fight this enemy, that is three times more deadly than war.

Magazines, newspapers, radio spot announcements, and twenty-two national radio commentators have done much to bring the campaign before the public. The Woman's Auxiliary to the California Medical Association has done its part, and eighteen county auxiliaries have reported.

Eight public meetings were held; tables were manned during the Society's membership drive; radio time was donated; educational films were shown; and members helped individually in more ways than can be mentioned. The benefit tea given by Los Angeles County Auxiliary was another splendid activity. Sonoma County Auxiliary carried the entire work for the Cancer Society most effectively. Bakersfield, Kern and Santa Barbara counties each made donations of \$50. Other societies have given amounts ranging from \$5 up. Two societies did not meet until May, so the total donated cannot be given in this report.

Due to unprecedented interest, the campaign could not be closed at the end of April, but was extended into May. Any donation marked "Cancer" and addressed to the postmaster will reach the American Cancer Society. The postmaster general has designated a city in

each state as a clearing house for funds sent by mail, therefore, all counties will receive due credit for gifts from their communities. This plan makes it easy for everyone to give and answers the question, "Where shall I send my donation?"

Let us continue to help in every way possible, especially encouraging individual gifts, that we may all "Guard those we love."

Respectfully submitted,

(Signed) CELIA R. BRINES, *Chairman*  
*Cancer Control Committee.*

## National Cancer Institute Act

*Its Administration from August 5, 1937, to June 30, 1944*

The National Cancer Institute Act, signed by the President on August 5, 1937, was recognition by Congress of the fact that greater efforts should be made to combat the ever-increasing mortality from cancer in the United States. Many factors have contributed to lengthening the span of life and to the gradual shift in the age groups of our population so that more and more men and women are living to reach the cancer age. By 1936 the mortality from cancer had reached the point where it accounted for approximately one death in every 10. The fact that the name of every member of the United States Senate was signed to the bill introducing the National Cancer Institute Act is evidence of the public consciousness of this problem. The act created in the Public Health Service a division called the National Cancer Institute, to be devoted exclusively to work which it was hoped would result in improving the treatment for cancer and in lowering the death rate from this disease.

The law states that the purposes of the Institute are—conducting researches, investigations, experiments, and studies relating to the cause, diagnosis, and treatment of cancer; assisting and fostering similar research activities by other agencies, public and private; and promoting the coordination of all such researches and activities and the useful application of their results, with a view to the development and prompt widespread use of the most effective methods of prevention, diagnosis and treatment of cancer.

The Institute was organized as a division of the National Institute of Health of which Dr. L. R. Thompson was director. Dr. Carl Voegtlin was appointed the first chief.

Since this law was the first national effort in this country in the field of cancer, the administrators responsible for initiating the work had no model to guide them other than the law itself which, while specific on many points, was still general enough in its terms to allow wide latitude in the Institute's activities.

### Appropriations

The appropriations for the work of the Institute from August, 1937, to June 30, 1944, have been as follows:

Fiscal Year Ended June 30	Appropriation
1938 .....	\$400,000
1939 .....	400,000
1940 .....	570,000
1941 .....	570,000
1942 .....	565,000
1943 .....	†534,870
1944 .....	†530,000

† Exclusive of funds for printing and travel.

### National Advisory Cancer Council

One of the first steps in the organization of the work of the Institute was the appointment of the members of the National Advisory Cancer Council, an advisory body created by the act, which consists of six members with the Surgeon General as chairman ex officio. The Surgeon General cooperates with the Council in carrying out the powers and duties imposed by the act. The law provided that the first six members were to be appointed

in groups of two for 1, 2, and 3 years respectively. As each group completed their terms, their successors were to be appointed for 3-year terms. As a result of this provision two members of the Council are appointed each year, and a continuity of activity is provided which would not be possible if all members completed their terms at the same time. No member may succeed himself, but he may be reappointed after 1 year.

## CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

### Medical Officers of U.S.P.H.S. Now Part of Military Forces

Washington, June 27.—(A.P.)—President Truman by executive order today declared the commissioned personnel—about 3,000 physicians, dentists, sanitary engineers, pharmacists, nurses and scientists—of the U. S. public health service to be members of the military forces for the duration of the war.

The order gives this personnel the same status, benefits, discipline and obligations as members of the other branches of the military.—*San Francisco Chronicle*, June 28.

### Illegitimacy Clause Killed in Baby Adoption Bill

Taking cognizance of widespread opposition by servicemen organizations and the protest of the *Stars and Stripes*, Army newspaper, the Senate Judiciary Committee of the California Legislature on June 14, struck out the provision of the Johnson baby bill which permitted a married mother to give an illegitimate child in adoption without consent of or notification to her husband.

The measure as it remained, merely provides a procedure for a prospective adoptive father to be represented in court in an adoption proceeding through power of attorney. The bill does not relate to the rights of either a natural or a legal father, unless the natural father chances to be the one who wants to adopt a baby.

Assemblyman Gardiner Johnson of Berkeley, in asking elimination of the provision which had brought an outcry that it would condone faithlessness on the part of the wife of a man in military service abroad, told the committee that it had been found impossible to draft an amendment which would meet the objectives of the State Social Welfare Department and the objection of the critics.

### Psychiatric Consultants Abroad

Five of the most prominent American civilian psychiatrists are now touring all Army headquarters installations in Europe to study the psychological factor in the combat infantry soldier and methods of psychiatric treatment now in use.

It is expected that they will make recommendations on the correlation of the methods of treatment and the mental attitudes of battle-weary soldiers.

The psychiatrists are: Dr. Karl Menninger, Chief of the Menninger Clinic at Topeka, Kansas; Dr. John Romano, Professor of Psychiatry at the University of Cincinnati School of Medicine, Cincinnati, Ohio; Dr. Leo Bartemier, Professor Psychiatry, at the Wayne University School of Medicine, Detroit, Michigan; Dr. John Whitehorn, Professor of Psychiatry, the Johns Hopkins University School of Medicine, Baltimore, Maryland; and Dr. Lawrence Kubie, Assistant Professor of Psychiatry

at Columbia University College of Physicians and Surgeons, New York City.

The group left for the European Theater of Operations on April 20, under the auspices of Office of Scientific Research and Development.

### Appeal for Release of Medical Officers Who Are Not Needed By Armed Forces

The Executive Committee of the Indiana State Medical Association, at its regular monthly meeting June 17, 1945, authorized the publication and distribution of the following statement:

Now that V-E Day is passed and we are expecting the release from service of part of our Armed Forces, immediate consideration should be given to the release of as many of the doctors as is consistent with the best interest of the Armed Forces and of the civilian population. Promptness in reducing the size of the Medical Corps should be the positive aim of everyone having responsibility in this field. There should never be a time when any doctor is being kept in the military service with nothing for him to do professionally in connection with his military status. He should not be kept in the service to do things which could as well be done by those not trained as physicians. Many persons have delayed obtaining the medical care they should have had until their regular physicians get back from the war. The doctors in the service have written a glorious chapter in the history of American medicine. . . .

The Executive Committee of the Indiana State Medical Association urges that those in authority look upon the early and prompt release of physicians, when they can be spared, as a matter of the utmost urgency and importance,—and when we say "when they can be spared," we must be understood to mean that every soldier, sailor, marine, nurse, WAC, WAVE, or SPAR, or anyone else who needs medical care in connection with military services will have it, even without the physicians who are to be dismissed. But after all the Armed Services are taken care of, any delay in releasing a physician should be avoided as an injustice to the public, an unnecessary burden on the treasury, a source of criticism of those in authority, and unfair treatment of the physician who is serving his country.

### Army Plans Special Care For Paralyzed

Top-ranking medical officers of the Ninth Service Command at Hammond Hospital, in Modesto, on June 27, recommended concentration of Army paralysis cases in two of the command's hospitals to further specialized treatment and rehabilitation of the injured veterans following a conference at that hospital station.

Although not specified, the recommendation implied that Hammond Hospital and McCaw in Walla Walla, Wash., should be selected.

The conference also established a uniform schedule of care to aid the veteran at whatever hospital he might be stationed and recommended that vocational training be started with the arrival of the veteran at the hospital.

Clinics and demonstrations revealed the therapeutic aid of wind musical instruments in developing patients' chest muscles and relieving organic complications and of the value of swimming exercise.

Rehabilitation programs stressed the development of hand skills, such as leather working, plastics, wood-working and writing, to enable the men to become self-supporting.

Medical officers participating in the conference included Hammond's commanding officer, Colonel L. R. Poust; Colonel Luther Moore, Ninth Service Command surgeon; Lieutenant Colonel M. G. Beaver, command surgi-



cal consultant, and Lieutenant Colonel J. J. Loutzenheiser, command orthopedic consultant.

### Surgeon General Kirk Reports on Malaria Effects

Fear due to lack of information can cause more harm than malaria itself, Major General Norman T. Kirk, Surgeon General of the Army, declared in his first public report on the effects of this disease on the individual.

With the prospect of thousands of soldiers returning to this country from malarious regions, General Kirk made an appeal for a better understanding of the problem so the public will realize that, with a few simple precautions, malaria is not a disease that should give undue concern either to infected service men or to their families. . . .

There are a number of types of malaria, but the two that concern American troops are benign tertian malaria, which is rarely a serious disease, and malignant tertian malaria, which without treatment may be fatal. The latter type is cured by atabrine so that it is not a problem when properly treated. The attacks of malaria which soldiers will suffer after return to this country will be due to benign tertian malaria. This is the one type which is of military significance to American troops.

The service man infected with benign tertian malaria can continue with his usual arduous combat duties as long as he takes the necessary small doses of atabrine. Benign malaria is rarely cured by atabrine. However, this drug suppresses the disease. When a man with benign malaria stops taking atabrine, the usual symptoms—chills, fever, headache, and nausea—may appear.

In the majority of cases the disease has run its course after a man has suffered a few relapses, and no permanent damage has been done. Out of 1,000 cases, about one-third will have only one attack. There will be about 40 out of 1,000 who will suffer ten relapses, and only about one in 1,000 will have as many as 20 attacks. Relapses become less acute as time goes on.

When attacks do occur, the symptoms are rapidly relieved and all progress of the disease is quickly suppressed if the proper medical care is given the patient. In most cases this can be accomplished within 48 hours, according to General Kirk. . . .

General Kirk stressed the point that malaria can be spread only by the anopheles mosquito. Even if a man is infected, the anopheles mosquito cannot transmit the disease unless it has bitten the victim during a relapse and before medical treatment has been secured. In most parts of the United States there is little likelihood of this since mosquito control measures are adequate.

Infected individuals who are not taking regular suppressive medication are particularly subject to relapses if they engage in strenuous work, or if they suffer from exposure, or if they indulge in drinking to excess.

One phase of malaria treatment that causes concern to many victims is the yellow color the skin takes on as a result of using atabrine. This color is not due to jaundice or any other malfunctioning of the body. It is caused directly by the yellow color of atabrine which is deposited in the skin. The yellowness will disappear a few weeks after the use of the drug is discontinued.

Deaths due to malaria since the beginning of the war have been rare. They are nearly always associated with other diseases and with circumstances which cause delayed or inadequate treatment, Army records show. In the early stages of the Pacific war, malaria did more damage to American soldiers than Jap bullets—in disabling troops, but not in killing them.

Peace and friendship with all mankind is our wisest policy, and I wish we may be permitted to pursue it.

—Thomas Jefferson, *Letter to C. W. F. Dumas*, 1786.

## CALIFORNIA PHYSICIANS' SERVICE†

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\* \* \*

### Executive Staff

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### Beneficiary Membership

	March, 1944	March, 1945
Commercial Program .....	61,200	133,000
Rural Health Program.....	1,999	2,040
Housing Program.....	22,623	12,100
Total Membership .....	85,822	147,140

† † †

The recent legislative victories with respect to compulsory health insurance should cause members of the profession to re-evaluate years of steps the medical profession has taken in anticipation of the ever-threatening menace to the practice of medicine.

From many legislators, the Public Health League, officials of the California Medical Association and public relations counsel now comes word that the presence of a physician-sponsored plan (California Physicians' Service), dedicated and actually at work in a sincere effort to develop prepaid medical care for the low income people in this State, was perhaps singly the most significant factor in these victories. Without such an organization there would have been little other than age-old arguments regarding principles and philosophies, etc., which have been rapidly losing weight as a method of combating the issue of compulsory insurance.

California, of course, was the first State in the Union to have formulated a State-wide prepaid medical service. Let us try now to forget the early difficulties that C.P.S. had to go through to achieve its present successes, and back it to the hilt. The program of C.P.S. in this coming year will be directed toward expansion, with a goal set to double or triple our present membership of 150,000. There are already indications, evidenced by the growing support of industry and the farm groups in C.P.S., that this goal may be achieved at an early date.

One of the by-products of the recent legislative session has been the awakening of our neighboring states to the value of a physician-sponsored plan. Definite interest has been shown by Nevada, Montana, Idaho and Arizona. These states have relatively small populations, and with the exception of Idaho, (where a plan started and failed) have had no experience in developing a medical service plan. Recently C.P.S. has offered to help these states. With its experience and trained personnel, it is believed that C.P.S. could help these states to get off to a good start. Once the other plans could stand on their own feet, they of course would be operated by the Medical Associations of those states.

Aside from the political advantages of a solid block of Western states all engaged in prepaid medical service,

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

there are certain practical advantages of mutual value. C.P.S. is now actively engaged in enrolling membership in large corporations. Many of these have employees outside of California. In the past this has been a distinct disadvantage, because we were not able to cover out-of-state members. With reciprocal arrangement with other plans, this would now become possible, and would open entirely new fields for massive enrollment of new membership.

### Supplement to Report of Board of Trustees of California Physicians' Service

(Covering May, 1944 to March, 1945. For other report, see CALIFORNIA AND WESTERN MEDICINE for April, 1945, pp. 223-225.)

The Board of Trustees desires to supplement its annual report for the year ended March 31, 1945, heretofore presented to all of the administrative members. The board desires to supplement this because it feels very strongly that both administrative and professional members should be fully advised of the board's views with respect to the current campaign amongst certain physicians to reject the basic premise on which California Physicians' Service is built, that is, service, and to substitute a new premise, that is, indemnity.

It is well to recall that in the fall of 1938, when the California Medical Association studied plans for a voluntary prepaid medical care organization, two alternative plans were drafted: one for a service organization; and one for an indemnity insurance company. Both of these plans were presented to the House of Delegates at its special meeting in Los Angeles in December, 1938, although the Council in its previous recommendations to the House unanimously urged adoption of the service plan. As you know, the House of Delegates did adopt the service plan, and California Physicians' Service was thereupon created. Since that time, the question of service versus indemnity has frequently been debated, both within California Physicians' Service, within the California Medical Association, and within county medical societies. The American Medical Association House of Delegates has endorsed both service and indemnity, and this indecision has undoubtedly had some effect in keeping the subject alive in California. The basic arguments for and against each plan may be concisely stated.

In theory, indemnity is easier on the doctors. It is pure insurance of a type they can understand, since all have had some experience in caring for patients insured by life insurance or indemnity insurance companies, such as Aetna, California Western States, and John Hancock. Their type of coverage is indemnity, which offers only limited amounts of cash protection to the patients against medical and hospital charges.

In theory, a service organization is easier on the patients. If certain requirements relative to income are met, the doctor is obliged to make no charge to the patient and to receive his compensation from the Service funds. The patient—and this of course means the public—is thus assured of financial protection by agreements made within the profession itself.

We have used the term "in theory" advisedly, because in six years of experience operating a service organization we have found that neither of the two theories is proven one hundred per cent in actual practice. C.P.S. has been engaged for several years in direct competition with insurance companies that are functioning on an indemnity basis. From this competition, we have found that indemnity does not answer the problem of medical costs, that people do not want it if there is professionally supported medical service. In many instances, and especially in large groups where labor comes into the picture, this has been proved. Where the two have been

presented, insurance companies have withdrawn their sickness indemnity plans and urged C.P.S. and the Blue Cross to take the health coverage, in order that they might acquire the group life and accident and sickness benefits contracts.

In the cold field of actual cash, where indemnity seems to shine, all is not as perfect as some would have the profession believe. It must be remembered that an indemnity plan's schedules must be published telling the people exactly how much money they will receive for each of certain conditions. We do not need to tell the trouble insurance companies have had when this amount does not meet the physician's bill. No matter how small or big the print is saying that the amount may be only partial, the fact is that the patient—and again this means the public—thinks this is to be the fee. If insurance companies have trouble with a printed schedule, imagine what would happen if the medical profession itself published such a schedule. Insurance companies cannot set the doctor's fee, but the doctors certainly can set their own, and any schedule is bound to be interpreted as a fair fee for the profession, regardless of explanations. So the maximum has again been set, and there is no escape.

We have found, as stated before, in our six years of experience that the public generally, given a free and unhampered choice between a service plan and an indemnity plan, unhesitatingly chooses the service plan. However, we have also found in actual practice that the public does not as a rule have this free and unhampered choice, because a sufficient number of physicians object to the service form of organization and refuse to work with it. This produces a doubt in the public mind as to whether the service organization can "deliver the goods." We have been told time and again by men and women in all walks of life that only a service contract for the entire family in the lower income brackets will give needed protection; but at the same time we have been told again and again that until the entire medical profession realizes this fundamental fact, the public at large will not fully cooperate with any prepaid medical service plan. Instead, the public will be inclined to look with sympathy upon politicians who will secure complete medical service for it through government medicine, or will be inclined to patronize the plans of industrialists—company dominated medicine under which the doctor is a mere employee and has nothing whatever to say about his own welfare.

From our experience we are certain that the public will *never* accept indemnification as the final answer to the problem of the costs of medical care with respect to people in the middle or lower income brackets; although it will accept indemnification as the final answer for people in the upper brackets. The medical profession is thus faced with a very serious choice: Will it insist upon offering only indemnification, and thus run the very real risk of irritating the public to the point where compulsory government medicine will be accepted and enacted; or will the medical profession modify its natural desires for complete freedom to the extent of *cooperating* with its own service organization, and thus receive from the public good will and friendliness sufficient to bury forever the loud cries of minorities who want to subjugate the profession?

Again from our experience, we know that the public appreciates a prepaid *service* organization and feels that the medical profession by offering service is making a genuine and well-meant effort to assist people in time of financial trouble. People respond to an approach which they instinctively know is to their own best interests. Shall we now abandon this approach and substitute an entirely different method which does not have the same



public appeal? The Board of Trustees of California Physicians' Service feels that to make such a change would be to win a battle and lose a war; that the profession would gain a little bit of immediate freedom of action, but in the end would lose all freedom entirely. The board unanimously believes that the profession should not deviate in any respect from its established basic premise, that only a service contract can meet the needs of the lower income groups. C.P.S. cannot help the profession to beat compulsory health insurance under the banner of indemnification.

If indemnity is insisted upon and the public loses faith in doctors, the profession has only itself to blame for its own shortsightedness and rigid refusal to respond to this changing world. We may recall that the medical profession bitterly fought workmen's compensation laws, left the field completely to insurance companies and has paid the price in low fees, lack of control over physician-patient relationships and loss of power over industrial injuries ever since. Are we to repeat our folly? The Board of Trustees of California Physicians' Service urges—no. If indemnity is to be the basis of the medical profession's solution to prepaid medicine, the people and its legislators will draw the future pattern for the practice of medicine.

The banner of service may well be the flag of victory.

T. HENSHAW KELLY, M.D.

Secretary

## COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

### United States Cadet Nurse Corps

#### *An Appeal for Matriculants*

U. S. PUBLIC HEALTH SERVICE

#### *Facts and Figures*

To relieve the serious nursing shortage by producing graduate nurses more rapidly, Congress, in June, 1943, unanimously passed the Bolton Act making it possible for qualified young women interested in professional nursing to receive all-expense Federal scholarships under the U. S. Public Health Service. All students enrolling under the plan are members of the U. S. Cadet Nurse Corps.

At the present time, student nurses are giving approximately 80 per cent of nursing care in civilian hospitals operating schools of nursing. This Nation-wide replacement of graduate nurses by student nurses in our civilian hospitals has made it possible for greater numbers of graduates to go into the military and has also prevented the collapse of civilian nursing care here at home.

Corps members are not placed on the pay roll of the Federal Government. Schools of nursing approved under the Bolton Act receive allotments from the U. S. Public Health Service to help meet the cost of equipping and instructing Cadet Nurse Corps members.

This is a grant-in-aid program.

Applicants do not have to prove financial need in order to be eligible for the U. S. Cadet Nurse Corps as was the case in the former limited Federal nurse training program.

Any member of the Corps enrolled 90 days prior to the end of the war will be permitted to complete her training under the U. S. Cadet Nurse Corps plan.

*If You Are Accepted:*

*You Promise:*

As a Cadet Nurse that you will remain in military or essential civilian nursing for the duration of the war.

*You Will Receive:*

A complete nurse education and become a professional

registered nurse . . . Training in a State accredited school of nursing participating under the Bolton Act . . . The benefits of tuition and fees . . . Room and board . . . Books . . . Official Cadet Nurse winter and summer uniforms for optional outdoor wear . . . School indoor uniforms . . . A monthly spending allowance of \$15 during the first 9 months as a Pre-Cadet . . . \$20 a month for the next 15 to 21 months as a Junior Cadet . . . At least \$30 a month for the remaining months until graduation as a Senior Cadet.

Upon graduation, and as a Registered Nurse, you will be ready for employment in the essential nursing service of your choice.

*You Will Wear:*

Your official uniform with pride . . .

*Do You Qualify?:*

As an alert young American woman, are you qualified to respond to your country's call for 60,000 new student nurses? Test yourself on the following questions:

Are you between the ages of 17 or 18 (depending on State and school regulations) and 35?

Are you in sound health?

Are you a high school graduate in good scholastic standing, or have you had some college education?

Are you interested in people?

Do you enjoy the sciences?

Have you a sense of humor?

Have you an orderly mind? Are you neat?

Are you deft with your hands?

Are you quick to grasp what you see, read, hear?

Are you able to meet the entrance requirements of your chosen nursing school?

*Where to Apply:*

For detailed information on the U. S. Cadet Nurse Corps, get in touch with your local hospital. To join the Corps, apply to the nursing school of your choice. A list of the more than 1,100 schools participating in the Corps program may be obtained by mailing the coupon below.

Select the school that is *right for you*. Applicants are advised to secure information from at least three schools before making a decision.

U. S. CADET NURSE CORPS  
Box 88, New York 8, N. Y.

Please send free information and list of approved schools.

Name..... Age.....

Address .....

City..... Zone.. State.....

My education is: (Circle highest year completed)

High School: 1 2 3 4; College: 1 2 3 4; Grad.....

Present occupation .....

(If in school or not employed please indicate)

### Nurse Goals and the Record to Date

By July 1, the Army must have 60,000 nurses.

On May 1, the number serving in the Army was 51,000.

By July 1, the Navy must have 11,500 nurses.

On May 1, the Navy's need for nurses had been met.

By July 1, the Veterans' Administration must have 6,000 nurses.

On May 1, the number serving in the Veterans' Administration was 4,000.

Sixty-three per cent of the nurses serving with the armed forces as of July, 1944, had been drawn from the institutional nursing field. Mostly, they came from non-federal civilian hospitals, which in 1944 admitted

close to one-half million more patients than in 1943.

How did the hospitals carry on despite so great a loss of nurses?

The valiant services of thousands of nurses on hospital staffs, of student nurses, of nurses aides and other volunteers, as well as the superb response of inactive nurses to wartime needs, are responsible for the amazing volume of service hospitals have provided in these critical times.

### Shortage of Nurses in Civilian Practice

(COPY)

NATIONAL NURSING COUNCIL FOR WAR SERVICE, INC.

1790 Broadway, New York 19, New York

June 18, 1945.

*To the Editor:*—It is at the suggestion of Dr. Herman L. Kretschmer, president of the American Medical Association, that we are writing you.

We need your understanding and assistance in dealing with the shortage of nurses for civilian service. This shortage continues, even though the Army is no longer actively recruiting nurses. Nearly 25 per cent of all active nurses are now serving with the armed forces. Any marked reduction in the proportion needed is still in the future.

At least two resources can still be drawn upon in many communities: (1) inactive or retired nurses, who may be found and induced to return to active service; (2) nurses now doing less essential work who may be stimulated to take essential positions.

The assistance of the medical profession will continue to be extremely important in developing these resources locally. Whether by assigning private duty nurses to no patients but those acutely ill, or by encouraging office and other nurses who are not now making full use of their nursing skills to take positions where they can do so, or by utilizing a physician's natural contacts to locate inactive nurses, there is no question that the medical profession can be extremely helpful.

Dr. Kretschmer said in a recent letter to us: "I think the physicians can be of great help if they will conserve nursing personnel. I, personally, refuse pointblank to permit patients to have nurses unless they actually need them, even though the patients may be upset by the deprivation."

Sincerely yours,  
(Signed) ELMIRA B. WICKENDEN,  
*Executive Secretary.*

## COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

### Facts About Hospitals in 1944

#### HOSPITAL FACTS:

Average daily census in 1944.....	1,299,474
Total patient days of hospital care.....	475,607,484
Comparison with 1943.....	411,000,220
Number of babies born in hospitals in 1944...	1,919,976
Number of hospital beds in U. S. in 1944.....	1,729,945
Number of bassinets.....	80,791

#### WHERE SCIENCE AND MERCY MEET:

More than 8 years have been added to the average length of life in the general population of the United States through increasing mastery over disease by hospitals and medical science in the past 25 years.

Infant mortality is now less than half that of 25 years ago.

The average length of life is now approximately 62.8

years. When deaths by enemy action are discounted, the average rises to 64.2 years.

#### BETTER HEALTH FOR ALL:

Postwar expenditures of \$1,193,133,185 may be anticipated for the purchase of 180,826 new non-federal hospital beds to bring the national total to one for every 71 persons.

In addition, non-federal hospitals of the general and allied types plan to invest approximately \$177,000,000 on new construction after the war—\$12,880,000 on rehabilitation, \$3,400,000 on reëquipment, and \$13,133,000 on new equipment.

Five thousand varieties of commodities and supplies are purchased annually by hospitals at a cost of \$750,000,000. For each dollar in original investment in a hospital plant, \$.35 is spent yearly for commodities, supplies, and maintenance.

Prepaid hospitalization plans are a means toward Better Health for All. Blue Cross now has 17 million subscribers. In 1945, Blue Cross will pay \$90,000,000 for subscribers' hospital bills. Blue Cross is under individual community sponsorship. There were 400,000 Blue Cross babies in 1944.

One person in ten faces a hospital bill every year. Counting commercial and company plans, 37,000,000 Americans are covered by hospitalization insurance.

#### HOSPITALS FIGHT ON TWO FRONTS:

There are 60,000 doctors in the Army and Navy medical corps.

One out of 5 nurses is now in the service—when recruitment goals are reached, the ratio will be 1 to 4.

There are 44,000 nurses in the Army Nurse Corps—71 per cent overseas or assigned to overseas units. There are 9,165 nurses in the Navy Nurse Corps.

There are 274,405 registered active graduate nurses in the United States, plus 135,000 student nurses. . . .

The mortality rate among war wounded in this war is only 3 out of 100—2 out of 100 in the Navy.

To the end of 1944, the present war has cost the lives of 8,000,000 men killed in action or dead of wounds. This is roughly the same figure as the total of World War I.

*U. S. losses:* 200,000—between 3 and 4 times total for World War I.

*German:* Over 2½ million; 800,000 in 1944 alone.

*Japanese:* More than 600,000—far exceeding aggregate for all preceding wars in which she had engaged since she first began to emerge as a world power 50 years ago. Admits 168,999 killed and wounded in 1944, but death losses alone are estimated at between 350,000 and 400,000.

*Russian:* Over 2½ million; 550,000 in 1944 alone.

*British:* 125,000 dead; 2/3 from British Isles.

*French:* 10,000 to 15,000. British and French losses are still well below those of 1914-1918, largely because of the difference in the character of military operations in Western Europe in the two wars.

*Chinese:* 50,000.

*Former Axis Satellites:* 100,000, mostly Rumanians in Southern Russia and the Crimea. Hungary lost half as many as Rumania.

The year 1944 was the third in succession in which the total military death losses in action for all belligerents approached or exceeded 2 million; it was the fourth in succession in which the year's toll was on a scale comparable to the annual losses in World War I.

### Hill-Burton Federal Hospital Construction Bill (S. 191)

The Hill-Burton Hospital Construction Bill (S. 191) was introduced in the U. S. Senate, January 10, by



Senator Lester Hill of Alabama for himself and Senator Harold H. Burton, Ohio.

It calls for an appropriation of 110 million dollars, 5 million of which will be available to assist states in surveying their needs for additional hospitals. Another 5 million will be used to defray administration expenses, the remaining 100 million to be expended to aid states in constructing new hospitals.

On a state level the hospital survey and construction program will be administered by a designated state agency, assisted by an advisory council composed of representatives of "non-Government organizations or groups, and of state agencies, concerned with the operation, construction or utilization of hospitals."

A number of state legislatures have already enacted laws specifying the State health department as the State agency. The American Hospital Association and the American Medical Association have approved the bill; its passage is practically assured.

The bill defines a hospital to include "public health centers and general, tuberculosis, mental chronic disease and other types of hospitals and related facilities, such as laboratories . . . and central service facilities operated in connection with hospitals." This language, it may be presumed, would include what has been lately referred to as "diagnostic centers."

Some respectable leaders of medical opinion have questioned the desirability of building more hospitals and medical centers without first making sure that competent medical personnel will be available in the community to staff them. As Dr. Victor Johnson has said, "The mere construction of facilities is not in itself any guarantee to an area that it will have sufficient medical care of high quality."

The same is true of so-called diagnostic centers. To say that some areas lack "diagnostic facilities," a term used in practically all recommendations for improvement in medical care, is to miss the point entirely. What these areas need are well trained radiologists and pathologists, not "facilities." It is desirable that there be some understanding of just what is meant by all the talk one hears about diagnostic centers.

None of the agencies which have recommended the creation of diagnostic centers as a necessary step in improving medical service has clearly defined exactly what is meant by the term. Neither has there been any clear explanation of just how such centers are to be formed, by whom, and in what communities.

It seems doubtful that anyone would seriously recommend the creation of diagnostic centers in metropolitan areas or in small cities which now enjoy the services of private radiologists and pathologists. It may be presumed, therefore, that diagnostic centers are recommended only for sparsely settled areas for general practitioners who do not have easy access to the services of consultants in radiology and pathology.

Obviously the amount of diagnostic work to be done in such areas is not sufficiently large to attract private practitioners in radiology and pathology or such specialists would already have established practice there. The inescapable conclusion is that diagnostic centers in rural areas, with a full-time radiologist and pathologist in attendance, would have to be subsidized by private or state funds.

We can expect a considerable amount of discussion on these matters during the next few years. Radiologists should inform themselves concerning the proposals and should be prepared to advise interested agencies concerning the need for diagnostic centers, the nature of their services, and the method of their administration.

(Ed. Note.—A copy of the printed hearings on the

Hill-Burton Hospital Construction Bill (S.191) appeared as Job 72067 of the United States Government Printing Office, Washington, 1945. Application for a copy of the hearings held in February and March, 1945, the same being a report of some 318 pages, may be obtained by writing to the United States Government Printing Office, or to the U. S. Senate Committee on Education and Labor, James E. Murray of Montana, Chairman, or by writing one of the two Senators from California: Senator Hiram W. Johnson, or Senator Sheridan Downey of California, c/o U. S. Senate Office Building, Washington, D.C.)

### On Legal Obligation of California Citizens to Pay For County Hospital Care

(COPY)

Office of

DIRECTOR OF PUBLIC HEALTH

City and County of San Francisco

June 13, 1945.

To the Editor: Enclosed is copy of a letter from Mr. H. J. Riordan, Attorney for Bureau of Delinquent Revenue, regarding hospitalization in San Francisco public hospitals. I thought you would be interested in seeing the proper interpretation of the ruling.

Sincerely,

(Signed) J. C. GEIGER, M.D., *Director.*

(COPY)

CITY AND COUNTY OF SAN FRANCISCO

Bureau of Delinquent Revenue Collection

Tax Collector's Office

Room 107, City Hall

June 11, 1945.

Dr. J. C. Geiger

Director, Dept. of Public Health

101 Grove Street

San Francisco 2, California

Dear Sir:

This is to acknowledge receipt of and thank you for the clipping taken from the *Bulletin* of the San Francisco County Medical Society, entitled "City Loses in Hospital Case" citing an article which appeared in *CALIFORNIA AND WESTERN MEDICINE*, March, 1945.

The article refers to an action instituted by the City and County of San Francisco against Binnie Mitchell, also known as Mrs. William Perry, and states that persons receiving hospitalization in San Francisco public hospitals are not liable for the cost thereof unless an investigation is made by the proper authorities as to their ability to pay. This is a correct statement of law, but the article then points out that the action was for the recovery of services rendered the defendant at the San Francisco Hospital and that no evidence was offered as to the determination by the Board of Supervisors as to the pecuniary ability of the defendant to pay for the hospital services.

The report is not altogether accurate. The facts are as follows:

The action was based upon care and treatment rendered Julia Williams, the aged mother of Binnie Mitchell, alias, as a patient in the Infirmary of the Laguna Honda Home. Under the provisions of Section 2576 of the Welfare and Institutions Code, aid rendered to indigents shall be a charge against the spouse, parent and adult child of the recipient thereof and the company rendering aid shall be entitled to reimbursement therefor. This section further requires that the Board of Supervisors of the county rendering aid shall determine if the spouse, parent or adult child, or any of them, have

financial ability to support or contribute to the support of the recipient and were pecuniarily able to support or contribute to the support of the recipient during the time aid was rendered. The Court gave judgment in favor of the defendant because plaintiff failed to prove that the Board of Supervisors had made any investigation, finding, or determination as to the pecuniary ability of the defendant to contribute to the support of her mother, as required by the provisions of said Section 2576 of the Welfare and Institutions Code.

It should be observed, however, that there is a distinction between those cases where the county seeks reimbursement from the responsible relatives of persons who receive public aid and those cases in which the county proceeds directly against the person receiving such aid. Section 2 of Ordinance 18.102 (Section 151 or Article 3, Chapter 5, Part 11 of the San Francisco Municipal Code) provides that all persons admitted to the San Francisco Hospital belonging to the classifications hereinbelow set forth shall be investigated by the Director of Health and he shall determine the financial ability of such persons to pay, in whole or in part, for the institutional services rendered.

1. A physically defective and physically handicapped person under the age of 18 years, whose parents are not financially able to secure proper treatment;

2. A dependent, or partially dependent, poor, sick person, who possesses the required residential qualifications;

3. A person in need of immediate hospitalization on account of accident or sudden sickness or injury, or by reason of sickness or injury caused by or arising in a sudden public emergency or calamity or disaster;

4. A person in the active stages of tuberculosis in wards established for the treatment of such persons; and

5. A person to be quarantined or isolated in the City and County Hospital with a contagious, communicable or infectious disease.

The foregoing ordinance was enacted pursuant to Section 6 of Chapter 761 of the Statutes of 1933, now incorporated into Section 2600 of the Welfare and Institutions Code, which provides that the Board of Supervisors of any county may establish its own policies with reference to the amount of property, if any, a person shall be permitted to have while receiving public assistance, to the end that so far as it is possible, an applicant for public relief shall be required to apply his own property to his support.

Summing up, it may be said that there are two distinct classes of persons against whom the county may seek reimbursement:

*First:* A spouse, parent or adult child of a recipient of aid provided that the Board of Supervisors shall have first determined if such spouse, parent or adult child, or any of them, had, at the time the aid was given, and have, at the time the matter is presented to said Board, sufficient financial ability to reimburse the county for such aid.

*Second:* In those cases wherein the Director of Health has determined that the person receiving public aid has financial ability to reimburse the county, in whole or in part, legal proceedings may be instituted against such recipient without necessity for any determination by the Board of Supervisors.

I have gone to some length in an endeavor to distinguish and delimit the holding in the Mitchell case because, by the very nature of their duties, the members of the medical profession are quite frequently in contact with those classes of persons whose right and duties are directly involved.

Very truly yours,

(Signed) H. J. RIORDAN, Attorney for  
Bureau of Delinquent Revenue Collection.

## COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

### California Tuberculosis and Health Association Activities

Strengthening of state and local health department programs, building the necessary hospital beds and providing for the family of the tuberculosis bread-winner under treatment are three goals of a program enunciated by Dr. Herman E. Hilleboe, chief, Division of Tuberculosis Control, U. S. Public Health Service, at recent symposia conducted by the California Tuberculosis and Health Association in Los Angeles and San Francisco.

Dr. Hilleboe pointed out that 26 states do not have a full-time tuberculosis control officer and that many are lacking in adequate field services. His division, through financial aid and the temporary loan of personnel and equipment, is ready to augment and improve state and local public health programs.

Dr. Hilleboe said that approximately 150,000 beds, based on the standard of  $2\frac{1}{2}$  to 3 beds for each death, is the minimum requirement for tuberculosis control in the United States. At present, there are approximately 100,000 beds, leaving a shortage of 50,000 beds. His division assumes that state and local communities want to provide the major share of the cost of construction of hospitals and additional beds and that it is proper that they should maintain jurisdiction over them.

To provide a certain minimum of social and economic security for the family of the man who is a patient in a tuberculosis hospital, the Social Security laws should be amended, he recommended. Unless some such attention is forthcoming the best benefits of medical care is largely offset by economic worries and the danger that the man will not remain in isolation until treatment is completed.

In advising local associations regarding case-finding, Dr. Hilleboe warned against overlooking the small industrial plants which ordinarily employ about 50 persons. He pointed out that after the war, industry expected to employ 70,000,000 persons, the majority in small plants.

Dr. Hilleboe said that whereas only from 10 to 15 per cent of the patients entering sanatoria have tuberculosis in an early stage, more than 70 per cent of the cases first reported through industrial surveys are in the minimal stage. He warned against attempting to diagnose on the basis of an x-ray examination alone and pointed out that lay workers too often forget that the miniature film project is only a screening process.

Rehabilitation should start with the discovery of the case, according to Dr. Hilleboe.

Although authorized to ask for an appropriation of \$10,000,000 for its first year, the division requested less than \$2,500,000 for the fiscal year, 1945, on the grounds that it could not widely expend any more at this time. The 1946 budget, already approved by the budget committee, calls for \$6,047,000. Of this total \$5,200,000 will be used for granting aid to the state. Research calls for the expenditure of \$250,000.

Dr. Hilleboe said that this appropriation represents far more than has ever been spent for tuberculosis research in a single year, but that under the division's plan it will have the effect of an expenditure of a million and a quarter dollars. Instead of spending the money for "an ivory tower" for a small isolated group of scientists, it will be systematically fed into laboratories and research departments throughout the United States to augment existing facilities and personnel.



### Diphtheria in San Francisco—1945

San Francisco, June 18, 1945.

*To the Editor:*—On May 7 of this year a report on diphtheria was made at the beginning of what seemed to be a definite upward trend. After six weeks, the incidence still remains at a high level.

The following tabulation is submitted for a comparable period over the past five years:

<i>Jan.-June 15</i>	<i>Cases</i>	<i>Deaths</i>
1941.....	17	3
1942.....	14	3
1943.....	25	5
1944.....	11	1
1945.....	41	7

Total cases for less than six months of 1945 equal the total for the entire year of 1944. Seven deaths have been reported in the current year, a greater number than any annual total since 1938, when there were nine deaths reported.

The distribution of cases is such that little significance can be attached to seasonal incidence except that 28 cases were in adults. Likewise, for the year ending June 16, 1945, 6 cases were reported, 5 were in children, and only one of these had been immunized.

It is desired to emphasize that immunization against diphtheria will eliminate this disease and parents are urged to avail themselves of the many opportunities for this by many agencies in San Francisco, particularly the Department of Public Health.

Sincerely,

(Signed) J. C. GEIGER, M.D.

*Director of Public Health,  
City and County of San Francisco.*

### Second Lasker Awards for Fertility Research and Maternal Care Announced By Planned Parenthood

For the second successive year, two \$500 Lasker awards will be given through the Planned Parenthood Federation of America, Inc., for significant contributions to the improvement of maternal health care and for research in human fertility.

The two Albert and Mary Lasker Foundation awards were announced recently by Dr. J. H. J. Upham, chairman of the Federation's National Medical Advisory Council, who said: "We still know less about the science of reproduction than the science of mechanized warfare, and health care for pregnant mothers, in many parts of the country, is still 50 years behind medical knowledge."

Two similar awards were presented last January to Dr. John MacLeod of the Department of Anatomy, Cornell University Medical College, and to Dr. Felix J. Underwood, executive office of the Mississippi State Board of Health.

An individual wishing to qualify for the awards, or to suggest the name of a scientist, physician or public health official who might do so, should address the Medical Committee, Planned Parenthood Federation of America, 501 Madison Avenue, New York 22, New York.

### Medical Corps Sets Record on Okinawa

*New High Mark in Saving Lives Established by Doctors*

Okinawa, May 14.—Though the grim battle of Okinawa has become the costliest campaign of the Pacific war, one bright beam of hope shone tonight—the Tenth Army's Medical Corps has set a new record in saving the lives of steel shattered boys brought to their care.

Army, Navy and Marine casualties, on the basis of official reports, totaled more than 23,000 prior to the current bloody offensive on the island's southern sectors.

Of these, the greater majority were saved by the American medics' skill and the nurses' and corpsmen's care.

New Record

While the previous record of the Pacific war showed approximately 6 per cent of the casualties reaching Medical Corps aid eventually died, and 6.8 per cent died from wounds at Saipan, Okinawa's record stands at 3 per cent—only slightly above the 2.8 per cent tallied in Europe where, in the words of a Tenth Army surgeon, "they got everything they wanted."

The Tenth Army's chief surgeon, Col. Frederic B. Westervelt of Carlisle, Pa., explained the low rate at Okinawa:

"We did it by borrowing and stealing surgeons everywhere we could," Westervelt declared.

"We got equipment the same way; and taught every one how to save lives, not build reputations."

There is more to it than that simple statement, however, and mostly traced to good judgment and hard work of the surgeons operating eleven hospitals under Westervelt. Units with five operating tables have been handling as many as 200 operations in twenty-four hours, cases so bad that one man needed forty pints of blood, while another was on the table nine hours, holding up other urgent operations among the backlog of casualties.

Need Urgent

Without denying the wisdom of sending everything possible to Europe for finishing that job first, Westervelt nevertheless pointed out that—while having "as much surgical talent as we can use with the equipment we have"—the Tenth Army certainly can use more equipment.

Hospitals on Okinawa are of the field type designed to handle the usual run of garrison cases—illnesses, accidents, and so forth—but not 99 per cent surgery cases as combat hospitals are expected to do.

Westervelt explained that "there are no combat type hospitals in the Pacific," but hastened to add that the Tenth Army's equipment is "the best in the Pacific."

The chief surgeon credited the judgment of his men—good surgery—for the record. Nearly 100 Army nurses already are ashore and they are the best sports in the world, he added.—Julian Hartt, in *San Francisco Examiner*, May 15.

### Tomorrow's Country Doctor

The busy U. S. Army Medical Corps has found time to find out how many of the doctors now in service expect to return to their home communities after the war. Questionnaires sent to 21,029 uniformed medical men brought answers that 9,649 were determined to go back to their old places of residence and resume practice. Only 4,310 said they would not return to old practicing fields, others were not certain, and some said they never intended to be doctors again.

Many of the doctors in the armed services were not practicing before the war. They went from schools to hospitals and from internships to the services. Inasmuch as most of the older men indicated they would return to the larger cities, it is from the younger group that the country doctor of the future is to come. He may not look like the "old-fashioned country doctor," but he will be a man of modern training and concentrated experience.—*Oakland Tribune*, May 11.

### A Bill to Draft Medical Help for Veterans

A wartime draft to provide medical personnel for the Veterans' Administration was called for in legislation introduced on May 26, by Representative Rankin (R., Miss.) after a conference with President Truman.

The chairman of the House Veterans' Committee told

reporters the legislation, which he said would enable the Veterans' Administration to improve its medical organization, had the backing "in principle" of Mr. Truman.

Its details, he added, were not discussed at the conference with the President, which was attended also by Brigadier General Frank T. Hines, head of the Veterans' Administration.

"It will untie the Administration's hands in the selection of doctors and nurses and permit the payment of sufficient salaries to obtain the best available medical personnel to care for veterans," Rankin said. "It will permit the replacement of incompetent doctors with the type of medical personnel the veterans are entitled to."

The bureau would include a medical corps, a dental corps, a nurse corps, and an administrative corps under which would be dietitians, therapists and similar personnel.

At the head of the bureau would be a surgeon general and working with him would be five assistants paid from \$9,000 to \$12,000 annually.

#### Venereal Diseases Clinics—San Francisco Department of Public Health

A report under above caption, with date of June 12, 1945, has been received from J. C. Geiger, M.D., Director of Public Health for the City and County of San Francisco. Report follows:

The statistics cover the period from May 1, 1944, through April 30, 1945.

1. 1241 patients were under treatment for syphilis, during which time 23,631 syphilis treatments were administered.

2. 1559 patients were under treatment for gonorrhea, during which time 14,272 gonorrheal treatments were administered.

3. 100 per cent of the above gonorrhea patients were treated with sulfonamide, and those who failed on sulfonamide medication were given penicillin medication.

Some of these sulfonamide-treated patients were placed initially on penicillin therapy at San Francisco City Clinic in view of the fact that they had previously failed on sulfonamide medication. It is estimated that this represents from 10 per cent to 20 per cent of the patients who were treated during this period.

4. Review of the records at San Francisco City Clinic shows that 32 per cent of the gonorrhea patients treated on sulfonamide medication were found to have a positive gonococcal culture following an asymptomatic state. Some of the gonorrhea patients treated with sulfonamides failed to develop an asymptomatic state. Therefore, the actual failure rate would be higher than this; however, the records immediately available do not show the number of these patients.

It is estimated, however, that approximately 35 per cent to 40 per cent of our gonorrhea patients treated within the last year on sulfonamide medication have failed to respond satisfactorily to that medication.

5. 33 per cent of the gonorrhea patients under consideration were treated with penicillin.

6. Of all the gonorrhea patients at San Francisco City Clinic who were given penicillin medication of from 50,000 units to 200,000 units, which has been the treatment range, 17 per cent failed. It is of interest to note that the failure rate between the sexes are not significantly different.

It is important to point out that since October, 1944, all of our sulfonamide-resistant gonorrhea patients have been placed on 200,000 units of penicillin. Those patients who had been treated on 200,000 units of penicillin have shown a 15 per cent failure rate. Here, again, there has been no significant difference in failures among the sexes.

This observation is confirmed by other authorities.

Since May 7, 1945, we have discontinued the routine administration of sulfonamides to gonorrhea patients, and all patients are placed initially on penicillin therapy. This consists of the administration of 200,000 units of penicillin, administered at two-hour intervals over an eight-hour period, with the first injection of penicillin having twice the number of units of the subsequent injections.

7. Penicillin in oil requires the use of calcium penicillin, as sodium penicillin is not readily miscible in oil. Calcium penicillin consists of the mixture of the penicillin in 4 per cent beeswax and peanut oil. Calcium penicillin is not at the present time available to the civilian public.

Opportunity was available, however, to treat 53 patients on penicillin in oil, with a 4 per cent failure rate. One should not consider this figure at all significant because the sample is entirely too small and the observation period is not of prolonged duration.

8. During the time the patients received sulfonamide medication for gonorrhea 20 grams of sulfothiazole were administered over a five day period, the medication consisting of the administration of one gram of sulfathiazole at four-hour intervals, four times daily.

9. As above explained, we are now using 200,000 units of penicillin in the treatment of gonorrhea patients.

10. San Francisco City Clinic is not treating syphilis patients with penicillin.

The customary accepted dosage of penicillin for the treatment of syphilis patients varies from 1,200,000 to 2,400,000 units of penicillin. Unfortunately, the use of penicillin in the treatment of syphilis has become markedly confused, each investigator more or less using the dosages of penicillin he arbitrarily chooses, and the majority of them combining this medication with various amounts of arsenicals and heavy metal. This condition is very unfortunate because the medical profession has lost the opportunity of adequately evaluating the therapeutic efficaciousness of penicillin, itself, in the treatment of syphilis.

All those patients with primary and secondary syphilis who have been given rapid treatment through the San Francisco City Clinic have been referred to a local University Medical Service for such rapid penicillin treatment.

#### SUMMARY

Probably the most efficacious method of administration of penicillin will be in beeswax and oil, or some other preparation which delays the absorption of penicillin. It is further observed that it has been necessary to administer sodium penicillin at two-hour intervals in order to assure the maximum therapeutic value of the medication. Penicillin in oil, it appears, makes it possible to administer penicillin at easy intervals.

However, attention is directed to the fact that there is not at present information as to whether or not it is important to maintain a constant blood-level of penicillin in the treatment of syphilis, or if sporadic periods of high concentration and low concentration are desirable in the treatment of syphilis. These questions can only be answered by time.

It is anticipated that when calcium penicillin in beeswax and oil is available attempts to treat primary and secondary syphilis patients on an out-patient basis with penicillin will be made. The most recent reports from the United States Public Health Service rapid treatment centers indicate that during the present short observation period in the treatment of syphilis with penicillin, the therapy of choice is the administration of from 1,200,000 units of penicillin to 2,400,000 units of penicillin, com-



bined with five injections of clorarsen and three injections of heavy metal. However, it is definitely recommended that observation should follow this type of therapy until the true efficaciousness of penicillin, itself, has been adequately evaluated, which may be months or years.

Finally, it is of paramount importance to point out that penicillin is now publicly regarded as a panacea for the cure of gonorrhea and syphilis, and it is the generally accepted opinion that penicillin has proved to be more efficacious in the treatment of gonorrhea than it has in the treatment of syphilis. It is also necessary to point out that the administration of penicillin in the treatment of gonorrhea tends to mask the clinical symptoms of primary and secondary syphilis that might co-exist. The medical profession and public health authorities have an added responsibility in the treatment of gonorrhea over that which they had in the period of sulfonamide medication of gonorrhea in that there are likely to be more missed cases of syphilis because of the masking of the early clinical symptoms of syphilis by the treatment of gonorrhea with penicillin. Present indications are that all gonorrhea patients should be observed over a nine-month period following penicillin treatment for gonorrhea in order to assure the individual of freedom of syphilis infection and in order to protect the public health.

A letter gave additional information concerning syphilis:

June 23, 1945.

1. In 1943 venereal diseases cost national industry \$12,400,000.
2. The national cost of syphilitic insane is \$31,000,000.
3. The national cost for the syphilitic blind is \$10,000,000.
4. The number of cases of syphilis and gonorrhea reported in San Francisco since 1940 is as follows:

Year	Syphilis	Gonorrhea	Total
1940 .....	2,495	2,632	5,127
1941 .....	2,429	1,982	4,411
1942 .....	2,950	2,740	5,690
1943 .....	3,352	4,036	7,388
1944 .....	2,991	4,771	7,762

The projected rate of reporting of syphilis and gonorrhea for 1945, in accordance with our experience for the first half year of 1945, will be 10,000 cases which represents an increase of 14 per cent over 1944.

5. Syphilis is the cause of one out of every twelve first admissions to mental hospitals.

6. Fifteen per cent of patients with syphilis examined at the San Francisco City Clinic are found to have neurosyphilis, which would lead to insanity or paralysis if not treated.

7. Syphilis causes cerebral hemorrhage (stroke) and heart disease. About one per cent of the patients with syphilis examined at the San Francisco City Clinic have heart disease.

During one and one-half years (1944 and 1945) of performing serologic surveys, 34,000 blood tests were performed of which 3,300 were positive. Approximately 2,600 patients were diagnosed as having syphilis and of these almost 1,300 had no previous treatment or knowledge of their infection.

Any inability to continue such serologic surveys will result in failure to find 1,500 previously unknown syphilis cases a year. Approximately 10 per cent of these patients will become dependent upon official care because of failure to find them. This will result in an official expenditure for their care of approximately \$1,500 per year per person or \$225,000 annually. The expected dependency on community or family of these patients is estimated at approximately ten years.

## "Controlled Sterilization"

### *Bishop Favors Death for Sub-Normals*

Nottingham, England, May 20.—Bishop Ernest William Barnes of the Church of England today advocated euthanasia, or easy death, for defective children and medically controlled sterilization to lessen what he called the "scrub population."

"Fairly often we hear of a child being born pitifully defective in mind or body and of the parents' relief when it dies," the 71-year-old bishop of Birmingham told the annual Coöperative Congress.

"I am convinced that in such cases euthanasia should be permitted under proper safeguards. Equally, from a Christian standpoint, as I see the matter, there is no objection to medically controlled sterilization.

"We in England have avoided those problems, but they are problems which, for our national welfare, we must ultimately try to solve."

He said bad racial stock was a growing source of anxiety to thoughtful men in every country where Western civilization prevailed.

In the development of cattle, he declared, herds breeding at random sooner or later develop "scrub cattle." Under harsh social conditions of other centuries, he added, defective children were not able to survive, but today, with human social services, problem children grew up to create problem families, and consequently a scrub population was appearing and war intensified the process."

Dr. Barnes said science did not know enough of the laws by which bad or good qualities were inherited to lay down adequate rules for improving the qualities of racial stocks.

"We know," he added, "that mental defects are inherited and some improvement in present tendencies could be made by sterilizing our feeble-minded."—*San Francisco Chronicle*, May 21.

### 10,000 Insane Said Sterilized in California

A total of 10,000 insane persons have been sterilized in California, the *Journal of the American Medical Association* revealed on April 26.

California led the list of 30 states which have sterilization laws, followed by Virginia and Kansas.

The report, submitted by Birthright, Inc., of Princeton, N. J., an organization devoted to fostering a nationwide sterilization program, disclosed that a total of 20,600 insane, 20,453 feeble minded and 1,563 other persons have been sterilized in the 30 states listed.

### Sterilization Laws\*

CALIFORNIA AND WESTERN MEDICINE, in its issues of May, 1941, page 296 and June, 1941, page 360 printed two articles on "Vasectomy and Salpingectomy under California Law," by Hartley F. Peart, Esq.

The "Human Betterment Foundation" of Pasadena, California, has issued an interesting leaflet on "Human Sterilization Today," and other literature. The following is one of their tables:

TABLE

Of eugenic sterilization operations performed in the United States under state laws, up to January 1, 1940.

The following table shows the year in which the first sterilization law was adopted by the various states of the United States listed below; and the number of sterilizations performed under such laws up to January 1, 1940, males and females being segregated.

A similar table is compiled annually by the Human Betterment Foundation, 321 Pacific Southwest Building, Pasadena, California, from which organization copies

\* For other references on sterilization, see p. 47.

of this table and of other literature dealing with the topic of eugenic sterilization can be obtained by writing the Foundation.

State	Year First Adopted	Sterilizations Performed		
		Male	Female	Total
Alabama .....	1919	129	95	224
Arizona .....	1929	10	10	20
California .....	1909	7,058	6,668	13,726
Connecticut .....	1909	23	386	409
Delaware .....	1923	308	275	583
Georgia .....	1937	25	33	58
Idaho .....	1925	4	10	14
Indiana .....	1907	490	413	903
Iowa .....	1911	85	132	217
Kansas .....	1913	1,294	886	2,180
Maine .....	1925	14	151	165
Michigan .....	1913	484	1,550	2,034
Minnesota .....	1925	350	1,409	1,759
Mississippi .....	1928	146	360	506
Montana .....	1923	55	127	182
Nebraska .....	1915	146	226	372
New Hampshire ....	1917	65	330	395
New York* .....	1912	1	41	42
North Carolina ....	1919	178	680	858
North Dakota .....	1913	156	322	478
Oklahoma .....	1931	85	348	433
Oregon .....	1917	527	863	1,390
South Carolina .....	1935	1	23	24
South Dakota .....	1917	185	339	524
Utah .....	1925	120	101	221
Vermont .....	1931	53	140	193
Virginia .....	1924	1,442	2,011	3,453
Washington .....	1909	145	417	562
West Virginia .....	1929	1	42	43
Wisconsin .....	1913	151	916	1,067
Total .....		13,731	19,304	33,035

1. Voluntary sterilizations in state penitentiaries in the State of California, not included above—536.

2. The above figures were furnished by state authorities.

3. The states not listed, have no sterilization laws.

\*The New York law was declared unconstitutional in 1918.

### America's Hospitals—Their Functions

Despite shortages of nurses, laboratory technicians and doctors, American hospitals in 1944 gave four million more days of patient-care than in 1943. Dr. Donald C. Smelzer, president of the American Hospital Association, recently told a nation-wide radio audience when he was guest of honor on "Your America," the Mutual network program of the Union Pacific Railroad.

In his address, featured May 13 on "Your America" in observance of National Hospital Day, Dr. Smelzer announced that in order to meet increased public demand for hospital care, postwar building projects are proposed which will add more than 180,000 hospital beds to the nation's total. He pointed out that this figure does not take into account plans for government hospitals.

Dr. Smelzer's remarks on the program follow in full:

"In contrast to the Nazi and the Japanese, one of the ambitions of America has always been to preserve and protect human life. To this end, we have established fine hospitals, medical schools and research laboratories. As a result, we entered the war with more graduate physicians and surgeons than any other country.

"Similarly, we have developed more nursing schools. Latest figures showed that Japan had 50 schools of nursing, Germany 447. But we are training nurses in 1,435 schools, all of which are affiliated with hospitals.

"The hospital is the cornerstone of modern medicine and surgery. Years ago it became evident that the treatment of sickness and injury was not always practical when limited to the physician's office or the home of the patient. Yet it was not possible for every doctor to own the best equipment and facilities. The answer was found in the hospital, where doctors could share the implements of modern medicine, to the benefit of society in general.

"Today, hospitals have been improved and advanced until they are veritable monuments to health. And great strides have been made towards putting hospitalization within the reach of all, through such programs as the Blue Cross Plan.

"This is the American Hospital Association's non-profit program whereby hospital care is immediately available to more than 18,000,000 people at an average cost of a few cents a day for each.

"In 1944 the civilian hospitals of America gave four million more days of patient-care than they did in 1943. At the same time, we have 60,000 doctors in the Armed Forces, as well as nurses, laboratory technicians and other hospital personnel who have left to serve the Army and Navy. Thus the increased public desire for good hospital care has exceeded our means of serving, and the hospital people remaining have been sorely pressed for time and energy.

"But this had not halted plans for the future. Our non-federal hospitals are proposing postwar building projects which will add more than 180,000 hospital beds to our nation's total. At the same time, the hospital of the immediate future will be further improved, with an emphasis on home-like conditions and colorful interiors, plus countless innovations for health, comfort and efficiency.

"Recognizing the importance of the community hospital in the health and welfare of the people, American hospitals are cooperating in developing and executing a common approach to our mutual goal—'Better Health for All.' The member institutions of the American Hospital Association appreciate the support and interest of the American people, who have made possible our voluntary hospital system. The aim of all hospitals is to be worthy of the confidence and faith of the people."

### Government Sale of Surplus Hospital Equipment

Washington, May 24.—Rural hospitals and health centers can look for a major share of the hundreds of millions of dollars of medical equipment to be released by the Army and the Navy. A policy has finally been worked out at the Surplus Property Board to assure release of this material for public health use, first in areas that have no existing facilities, second in areas that have insufficient facilities. So great is the need of rural and small-town hospitals and clinics that there will be little equipment left for replacement.

This policy was achieved only after a long and bitter dispute between the Surplus Property Board and Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*. Fishbein had urged that this vast volume of surplus material not be released at once. Instead, he wanted it stored and released gradually in small quantities in order not to upset the market for manufacturers of medical goods. In addition, Fishbein insisted that huge quantities of certain supplies, such as bandages, could not be used because they differed somewhat from accepted standard sizes.

However, in a lengthy session at the office of U. S. Surgeon General Thomas Parran, Dr. Fishbein was



finally won over and even agreed to serve on the over-all board which will recommend on the disposal of medical supplies.

Three types of equipment will be distributed—public health supplies, surgical and therapeutic instruments, and pharmaceuticals. A board of public officials and physicians headed by Dr. Parran will recommend their allocation to Federal Security Chairman Paul McNutt, who will work through the Surplus Property Board. Actual allocation of the supplies within the States will rest with State boards to be composed of various Federal Government and State medical officials.

Note—Federal officials are worried lest the State boards become a weak link in the setup. They fear that, in areas of greatest need, State groups will not be anxious to aid in the equipping of Negro clinics and hospitals. Therefore, an effort will be made to work out rigid requirements in Washington. No building program is yet arranged to go along with the disposal of medical supplies, though every effort will be made to convert Army buildings into hospitals and clinics. . . .—Drew Pearson, in "Washington Merry-Go-Round," in *San Francisco Chronicle*, May 25.

#### Continuation Courses Desired by Many Medical Officers

A large percentage of doctors now on duty with the Army, Navy, Public Health Service and Veterans Administration want six months or more of further training in hospital or other educational work and want to qualify as specialists in some branch of medicine after the war. These desires were expressed in answer to a questionnaire sent to each medical officer. The results have been reported by Lieut. Col. Harold C. Lueth, surgeon general's liaison officer.

More than 35 per cent of all medical officers on duty are represented in the questionnaires studied. Of these, nearly 60 per cent want to take six months or longer courses and 63 per cent want to become certified specialists.

#### Combat Badges for Medical Personnel

A Medical Badge has been authorized by the War Department in "recognition of the service rendered during combat" by members of the medical department assigned or attached to the infantry. It is of silver metal, elliptical in shape, with the medical department's insignia, the caduceus, and the Geneva Cross superimposed on a litter surrounded by a wreath of oak leaves. It will be worn on the left breast above decorations and service ribbons.

The badge will be awarded to medical department personnel regularly assigned or temporarily attached during combat to the medical detachment of the infantry regiments, battalions or elements thereof since Dec. 7, 1941.

Since members of the medical department are protected personnel under the terms of the Geneva Convention, the right to wear the badge may be temporarily withdrawn upon transfer or assignment of the individual to duties other than medical in which he may come in contact with the enemy. In such cases, the right to wear the Medical Badge will be restored on relief from combat duties or on reassignment to the medical department.

Regimental commanders are authorized to make the award for "satisfactory performance of duty under actual combat conditions." They also are given the authority to withdraw the badge if the individual fails to perform his duty satisfactorily.

## COMMITTEE ON INDUSTRIAL PRACTICE

### Occupational Diseases in Los Angeles

The Industrial Hygiene Division of the Los Angeles City Health Department has been active in following-up the occupational disease reports from the State Industrial Accident Commission. Table 1 shows the distribution of major classes of occupational diseases according to area.

Table 1.—Distribution of Reported Occupational Diseases for Six Months' Period, October, 1944 to April, 1945

Class	Calif. State	L. A. Area	L. A. City	Per-	Per-
				centage of State cases in L. A. City	centage of L. A. Area cases in L. A. City
Dermatitis . . . . .	2681	1402	646	24.1	46.1
Conjunctivitis . . . . .	1342	655	351	26.2	53.6
Inflam. Cond.* . . . .	775	381	148	19.1	38.9
Systemic Effects . . . .	211	82	42	19.9	51.2
U.R.P. & B. Aff** . . .	94	41	21	22.3	51.2
All Classes . . . . .	5103	2561	1208	23.7	47.2

\* Inflammatory Condition: apophysitis, bursitis, epicondylitis, fascitis, tenosynovitis, etc.

\*\* Upper Respiratory, Pulmonary and Bronchial Affections.

During the month of April the Industrial Hygiene Division made 129 visits to 98 plants, affecting 100,000 workers in an effort to eliminate and prevent these conditions.

Table 2.—General Causes of Dermatitis for March, 1945

Cause	Per Cent	Cause	Per Cent
Chemicals . . . . .	30.4	Foods . . . . .	5.0
Oils . . . . .	11.8	Acids . . . . .	3.1
Alkalies . . . . .	8.1	Paints . . . . .	2.5
Petroleum Prod. . . . .	8.1	Rubber . . . . .	2.5
Solvents . . . . .	6.2	Infections . . . . .	1.9
Dusts . . . . .	5.6	Plants . . . . .	1.9
Metals . . . . .	5.6	Miscellaneous* . . . .	1.9
Physical Agts. . . . .	5.6	Gases . . . . .	..

\* Such as wood, leather, wool, glue or unspecified.

Dermatitis comprises  $\frac{1}{2}$  of the total of occupational diseases. Table 2 shows the breakdown of the general causes of dermatitis in Los Angeles City. The important specific causes have been "Velite" plastic, cutting oils, metal and dishwashing cleansers, paint, lacquer and dope solvents, and glass wool such as "Fiberglas." Many of these dermatoses can be prevented by personal protective clothing, ointments, substitution of non-toxic materials and promotion of personal hygiene, etc.

I believe in the United States of America as a government of the people, by the people, for the people; whose just powers are derived from the consent of the governed; a democracy in a republic; a sovereign nation of many sovereign states; a perfect union, one and inseparable; established upon those principles of freedom, equality, justice and humanity for which American patriots sacrificed their lives and fortunes. I therefore believe it is my duty to my country to love it, to support its constitution, to obey its laws, to respect its flag, and to defend it against all enemies.

—William Tyler Page, *The American's Creed*. Accepted by House of Representatives, on behalf of the American people, 3 April, 1918.

Liberty has still a continent to live in.

—Horace Walpole, *Letter*, 17 February, 1779.

America means opportunity, freedom, power.

—Emerson, *Uncollected Lectures: Public and Private Education*.

# MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

## NEWS

### Coming Meetings†

*California Medical Association.* Session will convene in Los Angeles. Dates of the seventy-fifth annual session, to be held in 1946, will be announced later.

*American Medical Association.* The 1945 Session, previously scheduled for Philadelphia, will not be held.

### The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in *CALIFORNIA AND WESTERN MEDICINE* for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

### Medical Broadcasts\*

*The Los Angeles County Medical Association:*

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a. m., under the title, "Your Doctor and You."

In July, KFAC will present these broadcasts on the following Saturdays: July 7, 14, 21, and 28.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

\* County societies giving medical broadcasts are requested to send information as soon as arranged.

### Pharmacological Items of Potential Interest to Clinicians\*:

1. *Books Can Be Peaceful, Too:* E. Huntington's *Mainsprings of Civilization* might help San Francisco conferees (Wiley, New York 16, 660 pp., \$4.75, 1945). R. R. Grinker and J. R. Spiegel's *Men Under Stress In and After Combat* may also be helpful for the harder problems of peace (Blakiston, Philadelphia 5, \$5, 1945). Harvard Press announces important new ones: R. J. Dubos's *Bacterial Cell* (500 pp., \$5, 1945); C. K. Drinker's *Pulmonary Edema and Inflammation* (200 pp., \$3, 1945), and F. M. Burnet's *Virus as Organism: Evolutionary and Ecological Aspects of Some Human Virus Diseases* (150 pp., \$2, 1945). Spot-lighting the importance of word-symbols is George Stewart's fine *Names on the Land* (Random, New York, \$3, 1945). J. N. Lott and R. H. Gray offer *Law in Medical and Dental Practice* (Foundation Press, Chicago 6, 499 pp., \$4.75, 1945). P. DeKruif finally shows his age in *The Male Hormone* (Harcourt, New York, 243 pp., \$2.50, 1945). It is now Henry Schuman who goes to town: T. E. Keys' important *History of Surgical Anesthesia* (244 pp., \$6, 1945); J. M. D. Olmstead's definitive *Francois Magendie* (304 pp., \$5, 1945); W. Beaumont's *Two Diaries* (ed. G. Miller, 144 pp., \$6, 1945); Index to the *Annals of Medical History* (most worthy tribute to F. R. Packard, out Nov. 1, \$10); a new edition of M. Frank's translation of L. Choulant's *History and Bibliography of Anatomie Illustration* (435 pp., \$12, 1945), and a new quarterly *Journal of the History of Medicine* (1st issue, January, 1946, \$7.50). Henry really is going places: see his delightful shop at 20 E. 70th, New York 21. M. G. Wohl edits excellent *Dietotherapy* (Saunders, Philadelphia 5, 1029 pp., \$10, 1945). W. Haymaker and B. Woodhall of Army Inst. Pathology offer useful *Peripheral Nerve Injuries* (Saunders, 227 pp., \$4.50, 1945). Macmillan announces serial publication of H. Gold and M. Cattell's *Cornell Conferences on Therapy*. To the Hoerber medical student series edited by Fred Zapffe have now been added D. Mainland's *Anatomy as a Basis for Medical and Dental Practice*, and C. H. Thienes' *Fundamentals of Pharmacology* (P. B. Hoeber, New York 16, \$7.50 and \$5.75, 1945). R. P. Wodehouse offers *Hayfever Plants* (*Chronica Botanica*, Waltham, Mass., \$4.75, 1945).

2. *Pharmacology Items:* F. Hawkins gives informative review of recent works on pharmacology of sulfonamides (*British Med. J.*, 1:505, April 14, 1945). R. L. Vollum and G. S. Wilson report that sulfonamide lozenges are of no value in preventing streptococcal sore throat epidemics (*Brit. Med. J.*, 1:545, April 21, 1945). P. K. Knoefel and G. Lehmann note behavior of gelatin fractions in body, finding rate of urinary excretion varying inversely with molecular weight (*J. Pharmacol. Exp. Therap.*, 83:185, 1945). R. J. Schachter shows that IV injections of 5000 units of cholinesterase alleviate symptoms of traumatic shock (*Am. J. Physiol.*, 143:552, 1945). C. H. Li and V. V. Herring report that adrenocorticotrophic hormone helps rats resist anoxia (*Ibid.*, p. 548). F. K. Bell and J. C. Krantz propose reasonable chemical assay for digitalis (*J. Pharmacol. Exp. Therap.*,

\* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacological Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.



83:213, 1945). K. Dixon shows that penicillin inhibits fibrinolysis (*Brit. Med. J.*, 514, April 14, 1945).

3. *Toxicology Items:* C. H. Clarke, H. Wyers, E. C. Butler & Co., offer helpful symposium on methyl bromide poisoning (*Brit. J. Indust. Med.*, 2:17-31, 1945). R. Lemberg and J. P. Callaghan find nearly half intake of TNT through skin or mouth is excreted in urine as aromatic amines with evidence of storage and destruction in body by reduction (*Austral. J. Exp. Biol. Med.*, 23:6, 1945). W. H. Forbes, F. Sargent and F. J. Roughton study rate of CO uptake, rate of CO reaction with Hb, and average time spent by blood in lung capillaries (*Am J. Physiol.* 143:594-621, 1945).

4. *Odds and Items:* English scientists as usual rise to the occasion with a splendid anonymous tribute to President Roosevelt (*Nature* 155, 475, April 21, 1945). Z. Vaz & Co. (Braz.) recommend calcium cluconate in prevention and treatment of DDT poisoning (*Science* 101:434, April 27, 1945). I. W. Sozer and C. E. Prokesch suggest tyrosinase for inactivation of poison ivy irritants (*Ibid.*, p. 517, May 18). G. N. Papanicolaou and V. F. Marshall describe urine sediment smear diagnostic test for cancer of urinary tract (*Ibid.*, p. 519). G. Holmes gives excellent Royal Society Ferrier Lecture on organization of visual cortex in man with point to point representation of retina in striate area (*Proc. Rev. Soc.*, B, 132:348, 1945). P. Weiss & Co. find distal flow of few mm./hr. of endoneurial fluid around peripheral nerves (*Am. J. Physiol.*, 143:521, 1945). H. M. Turnbull Festschrift contains L. D. Parsons' note on amyloid infiltration of liver and spleen from pentose nucleotide injection and S. T. Callender & Co.'s finding that RBC average life is 120 days and that normal rate of replacement is 0.83 per cent per day (*J. Path. and Bact.*, 57:9, 129, 1945).

**National Tuberculosis Seal Sale Tops Previous High by 20 Per Cent—California Leads.**—The sale of Christmas Seals in the United States during the 1944 campaign totaled \$14,966,000, according to Charles S. Newcomb, Seal Sales Manager of the National Tuberculosis Association.

The 1943 sale totaled \$12,521,000. This represents an increase in 1944 over 1943 of approximately 20 per cent, Newcomb explained.

Heading the association which built up the new record is the California Tuberculosis and Health Association which had a 1944 Seal Sale of \$1,238,621.27, an increase of approximately 16 per cent over its \$1,068,744.70 collected in 1943.

The next ten associations in Seal Sales totals are: Pennsylvania, \$1,219,780; New York State, exclusive of New York City, Brooklyn, and Queensborough, \$968,970; Ohio, \$888,769; New Jersey, \$625,353; Indiana,

\$596,886; Massachusetts, \$549,190; Michigan, \$526,849; Illinois, exclusive of Chicago and Cook County, \$493,030; Texas, \$474,355 and Minnesota, \$437,865.

"At this date," Mr. Newcomb said, "there are no reliable figures on estimated national income for 1945 but some authorities believe that there will be a shrinkage of at least 25 per cent."

"It seems probable that if we have any increase in 1945, they will be the result of momentum of the release of savings which will come into use when civilian goods are again available, which may be the fall of this year. In the meantime, reconversion may slow up employment to an extent that will be felt acutely during the summer months. Reemployment before the 1945 Seal Sale on November 19 may pick up the slack."

**San Jose Health Department on National Honor Roll.**—San Jose City Health Department won a place on the National Honor Roll, an honor which was granted to only one other California city during 1944, namely, Pasadena. In order to achieve this distinction this city met an approved standard for a well-balanced public health program. This award was granted through a joint program of the United States Chamber of Commerce and the American Public Health Association. The award consisted of a plaque and a certificate granted by the American Health Association showing this meritorious achievement.

Some of the outstanding things that won San Jose this award were the coordination of city and school nursing services, a splendid vaccination and immunization record for children under two years of age, an average rate for a five-year period of 2.5 per 1000 live births for maternal deaths, and 26.1 per 100 live births for infant deaths. The appraisal approved highly of study classes for food handlers, the family work in cooperation with the Santa Clara County Tuberculosis Association to discover persons with tuberculosis, and 100 per cent pasteurization of all milk served in restaurants.

The San Jose Chamber of Commerce with the United States Chamber of Commerce and the American Public Health Association co-sponsored the National Health Honor Roll in San Jose.

Health Officer Dwight M. Bissell, M.D., has brought off the press an interesting and instructive 24 page Annual Report of the San Jose City Health Department.

**Sterilization Operations in California Institutions**

In 1943-44, 137 fewer sterilization operations were performed than during 1942-43, a decrease of 26 per cent from the previous year. Of the total operations 44.8 per cent were performed at mental hospitals, 55.2 per cent at institutions for mental defectives. During 1943-44,

*Sterilization Operations Performed in State Hospitals and Institutions For Mental Defectives*

Institution	Year ending July 30, 1944			Cumulative totals for California through June 30, 1944		
	Total	Male	Female	Total	Male	Female
All institutions.....	397	161	236	16,517	8,387	8,130
Mental hospitals.....	178	62	116	10,643	5,764	4,879
Agnews .....	6	0	6	653	226	427
Camarillo .....	0	0	0	27	3	24
Mendocino .....	2	1	1	358	229	129
Napa .....	31	18	13	1,714	752	962
Norwalk .....	24	2	22	1,041	476	565
Patton .....	72	23	49	4,287	2,564	1,723
Stockton .....	43	18	25	2,563	1,514	1,049
Institutions for mental defectives.....	219	99	120	5,874	2,623	3,251
Pacific Colony .....	42	17	25	1,401	683	718
Sonoma .....	177	82	95	4,473	1,940	2,533

59.4 per cent of the operations were performed on female patients, 40.6 per cent on males. (See also, on pp. 43 and 44.)

**Penicillin and Gonorrhea.**—According to the single-injection doses of penicillin in oil and wax mixtures, and three-injection schedules employing water solutions of penicillin, now appear to offer the most efficient means of treating gonorrhea. This is indicated by three recent studies of more than 2,000 patients, reported in the May, 1945 issue of "*Veneral Disease Information*," issued by U.S.P.H.S.

The schedules were developed to fit the needs of the physician in private practice and the out-patient clinic where treatment must be completed in a relatively short time. Many of the cases included in one of the studies were treated in offices and out-patient clinics.

Results of the studies indicated that the methods of treatment used are effective, safe, and widely applicable. Few cases of allergic sensitivity were reported. No evidence of penicillin resistance was encountered, and there was encountered neither naturally penicillin-fast strains of gonococcus, nor indications of the development of penicillin-fastness under treatment. Ability of the methods to effect cure did not appear to be affected by sex or race of patients, or by failure of previous treatment.

One study was conducted at the Bellevue Hospital rapid treatment center, in New York City.

#### **Corneal Tissue Stored With 22 U. S. Hospitals.**—

It's doctors—not businessmen—who have organized America's newest bank, the Eye Bank for Sight Restoration, Inc.

Like its medical forerunner, the blood bank, the eye bank is a central spot where human corneas can be stored until needed for grafting operations that may restore vision lost through damage or disease. It is estimated that the blindness of five to seven per cent of the 250,000 sightless in the United States is caused by clouded or opaque corneas.

Chief asset of the new bank is its network of 22 depositors—hospitals already affiliated with the plan to provide an interstate system for the quick collection and distribution of human eyes. Until the bank was organized, the supply of corneal tissue for the operation which replaces a clouded cornea with a clear new one, always was far behind the demand and most hospitals had long waiting lists.

The headquarters of the bank, initially located at the Manhattan Eye, Ear and Throat Hospital, in New York, provides for the first time a nationwide deposit box in which human eyes can be stored until they are needed.

Although no figures are available, doctors estimate that most large eye institutions have not been able to do more than 50 such operations a year because of the difficulty of obtaining material.

Deposited by the bank's affiliated hospitals, the eyes may come from any of the following sources: live patients whose eyes may have been removed for other reasons although the corneas are unimpaired; dead patients who may have bequeathed their eyes to the bank, which can use them if they are removed within one hour after death; or stillborn infants, whose young, fast-healing corneal tissue is an excellent source.

The difference in size of the cornea of a stillborn child and an adult makes little difference, since surgeons generally use a corneal portion only about five millimeters square or round, depending on the size of the opaque part of the patient's cornea.

**DDT Gets First Civilian Use in Charleston, S. C.**—The United States Public Health Service has allocated enough DDT from the current production of 2,000,000 pounds per month to conduct a campaign in Charleston, S. C., against the anopheles mosquito, carrier of malaria. This will be the first civilian application for the new insecticide.

The program, which will cost \$130,000, and involve 40,000 persons, will involve spraying the interior of homes over a period of three months and a repetition of this procedure at the end of three months. After the results of the Charleston campaign have been learned, a similar program will be undertaken in 11 Southern states.

According to health department statistics, 46 per cent of the population in certain areas of North Carolina have malaria. DDT may be used against typhus and dysentery as well as malaria. The cost of the chemical basis of DDT has been brought down to only 60 cents per pound since large-scale production began.

**Art Works and Contest.**—The American Physicians Art Association, through the cooperation of Mead Johnson Company, announces the following Prize Contest:

**Subject:** "Courage and Devotion Beyond the Call of Duty"—on the part of members of the medical profession—in military or civilian practice. Any contestant may portray either the military or civilian aspect of the subject (or both, if shown in one piece).

**Media:** The physician-artist's choice of one of the following:

1. Painting in oil or egg tempera.
2. Water Color, transparent or opaque.
3. Sculpture in any medium.
4. Drawing in any medium.
5. Prints, including etching, engraving, lithography, wood block and linoleum block (on paper or cloth).
6. Photography, including bromoil, tinted and kodachrome, as well as photo-montage.

**Prizes:** Forty-two prizes will be divided among two groups of physicians:

(A) To Medical Officers:

1 \$2,000 War Bond (E or F series); 10 \$1,000 War Bonds (E or F series); and 10 \$500 War Bonds (E or F series).

(B) To Civilian Physicians:

1 \$2,000 War Bond (E or F series); 10 \$1,000 War Bonds (E or F series); and 10 \$500 War Bonds (E or F series).

Further information available on request of Secretary, Dr. F. H. Redewill, American Physicians Art Assn., Flood Building, San Francisco, Calif., U.S.A., or Mead Johnson & Co., Evansville 21, Ind.

**Medico-Legal Conference and Seminar.**—The Department of Legal Medicine of the medical schools of Harvard, Tufts, and Boston University in association with the Massachusetts Medico-Legal Society will present a six-day program of lectures, conferences, and demonstrations having to do with the investigation of deaths in the interests of public safety. Attendance during five of the six days of the course (October 1-6, 1945) will be limited to fifteen persons who have registered in advance. On one day (October 3) the program will be open to any physician, lawyer, police official, or senior medical student who may care to attend. Further information may be obtained from the secretary of the Massachusetts Medico-Legal Society, 25 Shattuck Street, Boston.

**Alcohol Problems—Societies.**—The "Research Council on Problems of Alcohol," 60 East 42nd Street, New York, recently welcomed the appearance of two new national agencies dealing with the problems of alcoholism—the National Committee for Education on Alcoholism and the National Committee on Alcohol Hygiene.

The "National Committee for Education on Alcohol-



ism" has opened offices at 2 East 103rd Street, New York City. It has been created to help educate the general public on the subject of alcoholism. Its specific aims are (1) to bring about the acceptance by the general public of five cardinal points: that alcoholism is a disease, that the alcoholic therefore is a sick person, that he can be helped, that he is worth helping, and finally that alcoholism is our Number 4 public health problem and our public responsibility; (2) to circulate sound scientific literature; (3) to help organize local committees; and (4) to help establish contacts between local committees and the nearest group of Alcoholics Anonymous so that they may coordinate their efforts if they wish. The Executive Director of the committee is Mrs. Marty Mann.

The "National Committee on Alcohol Hygiene" publishes a bi-monthly periodical and provides a scientific medical worker to speak before groups seriously interested in the problem of alcoholism and a research staff to organize and sponsor institutes. It provides consultation service for Community Chests and other groups to aid in the organization of diagnostic and treatment clinics. The Committee's office is at 2030 Park Avenue, Baltimore 17, Maryland, and the Executive Director is Robert V. Seliger, M.D.

There are now five national agencies dealing with this major public health problem—the "Yale School of Alcohol Studies," "Alcoholics Anonymous," the two new agencies just described and the "Research Council."

Karl M. Bowman, M.D., Professor of Psychiatry at University of California, is one of the six officers of the "Research Council on Problems of Alcohol."

**The Conquest of Smallpox.**—At last it seems that our country is about to join the ranks of the nations that have eradicated smallpox. Only 384 cases of this loathsome disease were reported in the United States during 1944. This is less than half the previous low record established the year before. In the area stretching from Maine to Maryland, there was not a single case last year; one Western States, Utah, also had a perfect record. In all, 12 States and the District of Columbia, which include more than one quarter of the total population of the country, were completely free of smallpox in 1944. Twenty-two States reported less than five cases per million inhabitants. The largest number of cases, in Indiana, was only 38. As recently as 1940 Minnesota and Iowa each had more cases than were recorded in the entire country last year.

**Whooping Cough on the Increase.**—Whooping cough is definitely on the increase both in Los Angeles and in the entire United States. There were 63 cases of whooping cough reported in Los Angeles for February; 110 for March; 154 for April; and 176 for May. There have been 569 cases so far this year in Los Angeles, as compared to 132 cases at this time last year; and 47,266 cases in the United States as compared to 34,214 cases last year.

Whooping cough is a serious disease in children under three years of age. More deaths are caused from whooping cough in Los Angeles than from diphtheria, poliomyelitis, or scarlet fever. Three-fourths of the deaths from whooping cough occur in the age group under one year. The Los Angeles City Health Department strongly recommends that all children should be immunized during the early part of the second half of the first year of life, and that all children under three years of age, who are sibling contacts, should receive convalescent or hyperimmune serum in appropriate doses.

Whooping cough vaccine may be obtained in combination with fluid or alum precipitate diphtheria toxoid, and

with alum precipitate diphtheria toxoid and tetanus toxoid. Evidence indicates that such combinations produce satisfactory response in the immunity status of all three diseases.

**Pertussis.**—United States vital statistics show a sharply accelerated decrease in pertussis morbidity and mortality. Ten years ago the average was 300,000 cases with 6,000 deaths (50 cases to a death); in 1942, 191,383 cases with 2,536 deaths (75 cases to a death). A more widespread application of early immunization, a better isolation of young infants from brothers and sisters and other people, and the use of hyperimmune serum in cases of contact, will further reduce these figures.

**Eighteenth Anniversary Issue of the Hebrew Medical Journal.**—Volume I, 1945, eighteenth anniversary issue of the *Harofe Hainivri* (The Hebrew Medical Journal), edited by Moses Einhorn, M.D., has just made its appearance. This special issue is dedicated to the late Henrietta Szold, distinguished humanist and Zionist, who harnessed American Jewish womanhood in a great organization, Hadassah, which is responsible for the vast network of medical and sanitary installations in Palestine, making it the outstanding health center of the whole of the Middle East.

It was in June, 1918, that Hadassah sent its initial medical unit to Palestine, which brought the first small measure of relief to that country's then war-torn and pestilence-ridden population. During the Second World War Hadassah was recognized and accepted as the driving force which has made, and will help keep, Palestine an oasis of health in the subtropical Near and Middle East areas.

For further information, communicate with the editorial office of *The Hebrew Medical Journal*, 983 Park Avenue, New York 28, New York.

**American Congress of Physical Medicine.**—The annual scientific and clinical session for 1945 of the American Congress of Physical Medicine has been canceled. This meeting was to have been held in New York City, September 5 to 8, 1945.

**Federal Venereal Disease Control.**—The "May Act" of July, 1941, which protects army and navy establishments against prostitution in areas where state and local law enforcement is unable to do so, has been extended by Act of Congress for another year, dating from May 15, 1945, when the original Act expired.

Congressman Andrew J. May, Chairman of the House of Representatives Committee on Military Affairs, and sponsor of the 1941 bill, introduced H. R. 2992, to cover the extension which, following a Committee hearing on May 1, was passed by unanimous vote by the House on May 7, adopted by the Senate on May 14, and approved by President Harry S. Truman on May 15.

**Wolfgang A. Mozart (1756-1791).**—From infant prodigy to an unidentified grave runs the brief life-span of this great musician-composer. Overwork and emotional strain took their toll; even at 26 he was in poor physical and mental health. He became obsessed with the idea that he had been poisoned, and the visit of an unknown emissary, asking him to compose a requiem, threw Mozart into a fit of terror. The man afterward proved to be the messenger of a nobleman who desired to publish the requiem as his own.—Warner's *Calendar of Medical History*.

## MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.  
San Francisco

(Concluded from Page 368—June issue)

### VASECTOMY AND SALPINGECTOMY FOR CONTRACEPTIVE PURPOSES\*

**Criminal Liability.**—At common law, sterilization constituted the crime of mayhem, since sterilization at that time consisted of castration. The gist of the crime of mayhem at common law was the deprivation of one's ability to serve the king or to defend himself, and, accordingly, no one was given the right to consent to the infliction upon himself of an injury likely to deprive him of such ability. The modern operations of vasectomy and salpingectomy apparently do not render the person impotent nor destroy his health in any manner; and it is, therefore, doubtful whether these operations would constitute mayhem under the common law definition of the same. However, California Penal Code, Section 203, provides for this state a definition of mayhem which is broader than the common law. The section states:

Every person who unlawfully and maliciously deprives a human being of a member of his body, or disables, disfigures, or renders it useless, or slits the nose, ear, or lip, is guilty of mayhem.

Under this section there is some doubt as to whether an operation which, though it does not destroy the physical strength or render the male impotent, yet renders an organ useless for the purpose of procreation, constitutes the crime of mayhem.

The California mayhem statute is discussed by the Hon. Justin Miller and Gordon Dean, Esq., in the March, 1930, issue of the American Bar Association Journal at page 159, as follows:

Some states apparently have departed entirely from the concept of the common law and make the crime consist in the unlawful and malicious removal of a member of a human being or the disabling or disfiguring thereof or rendering it useless. The operations of vasectomy and salpingectomy would render useless the procreative organs, in the sense that they would no longer be useful for procreation. For the gratification of sex desires, for satisfying the law as to potency, for committing the crime of rape, they would still be useful. In each case the answer might vary according to the point of view of the patient or of the judge.

... Where the statute speaks in terms of "rendering useless" a member or organ of a human being, there is the possibility of a decision either denying or establishing liability.

Hence, it is an open question whether sterilization of the male constitutes mayhem in California. There are no appellate court decisions in point. The only cases having any bearing are *People vs. Schoedde*, 126 Cal. 373, which, in effect, holds castration to be mayhem, and *People vs. Wright*, 93 Cal. 564, which holds that *malice aforethought* is not an essential element of the crime. From the case last mentioned, one can only conclude that *if* sterilization is, under some circumstances, mayhem, then consent of the patient is not a defense.

As the interpretation of the words "or renders it useless," which appear in Penal Code, Section 203, would depend to a large extent on the attitude of the courts concerning the morality of sterilization, search must be made as to the present attitude toward such operations. The Christensen case discussed and quoted in the first installment of this article, is, we believe, the only expression of any court in this country on this exact issue. Until recent

years the attitude of all civic bodies, as well as the courts, was that sterilization was immoral in all aspects. In California, and in many other states, public opinion has progressed to the point of approving sterilization for the purpose of rendering the unfit incapable of procreation and for the purpose of preventing pregnancy where the same would be likely to result in the death of the mother. As to how far one may safely go beyond these bounds, it is impossible to state. One California case, *People vs. Blankenship*, 16 Cal. App. (2nd) 606, expressed a qualified approval of sterilization with respect to those patients who are afflicted with venereal disease. In that case a criminal had been charged with the crime of statutory rape, but had been allowed probation upon the condition that he submit to sterilization. He appealed to the courts on the ground that such an operation would be an unfair condition of probation.

The Appellate Court made the following statement:

The state is vitally interested in the health and welfare of its citizens. It is certainly interested in preventing contamination of them by venereal disease. It may be conceded that intelligent medical science has succeeded in producing a cure for syphilis which is efficacious in the great majority of cases. However, as the trial court very properly observed, it was not so much concerned with curing the disease with which appellant was afflicted as it was with preventing appellant from transmitting the disease to his possible posterity. If reproduction is desirable to the end that the race shall continue, it is clearly desirable that the race shall be a healthy race, and not one whose members are afflicted by a loathsome and debilitating disease.

A New York case has, however, taken a different attitude. In *Foy Productions vs. Graves*, 3 N. Y. S. (2nd) 573, petitioners requested that the order of the Board of Education, which had denied them the right to show a moving picture relating to sterilization, be set aside. The Court, in denying the petition and upholding the act of the Board, stated:

"Tomorrow's Children" publicizes and elucidates sterilization as a means to prevent the conception of children, that it is a form of birth control, contraception without penalty, and that it is "an immoral means to a desirable end." It declares its own immorality. . . . The content of the picture is devoted to an illegal practice, which is, as a matter of common knowledge, immoral and reprehensible according to the standards of a very large part of the citizenry of the state.

Hence, we have one court considering sterilization for purposes of health (control of syphilis) to be legally justified, and another court vigorously condemning it when resorted to for purely contraceptive purposes. One can only conclude that sterilization operations are only proper in the eyes of the law when related to preservation of life or protection of health.

**Civil Liability.**—It seems to be generally believed that so long as the consent of the patient is obtained, the patient is not in a position to sue the doctor for the performance of an operation for sterilization. This may be a misapprehension since more than one case has held that if an act is illegal *per se* and a person suffers loss thereby, such person may recover against the actor regardless of his consent to the act. Whether or not this would be true in California in relation to sterilization, is purely a matter of speculation until there is a statute or decision on the point. However, the question of civil liability would depend first of all on whether or not the act should be criminal and, therefore, illegal *per se*.

It is true that in recent years there has been a tendency to enlarge the field within which sterilization is permitted. It is also true that under many state laws, and because of the lack of state laws, a physician cannot, without danger to himself, perform these operations in cases that seem to him meritorious. The law, as it stands, leaves very much in doubt the question whether or not such an operation may be performed, even with the consent of the patient, unless it is necessary to safeguard health or preserve life.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

\* For sterilization statistics, see pp. 43 and 47.



The answer to the problem could best be secured through the enactment of clarifying legislation. A physician, who chooses to act before this has been done, must do so with full knowledge that the consequences could be serious.

### Conclusions

For the present it is possible to draw the following conclusions from existing statutes and decisions:

1. Under no circumstance may a vasectomy or salpingectomy be performed upon any person for the reason that he or she may be mentally incompetent, feeble-minded, perverted, or otherwise subject to commitment in a state institution, but in all cases involving such persons the problem must be referred to the State Department of Institutions for whatever action it deems proper.

2. If a female patient who is not within Rule 1, above, requires a salpingectomy in order to *preserve her life or to safeguard her health*, then and only then it is permissible to perform the operation.

3. If a male patient who is not within Rule 1, above, is married and is living with his wife, and if his wife must not become pregnant for the *preservation of her life or health*, then, in order to avoid pregnancy, it may be legally proper to perform a vasectomy.

4. Assuming that a male who is not within Rule 1, above, could require a vasectomy in order to preserve his own life or health, then a vasectomy could properly be performed.

5. Except in the specific instances enumerated in the foregoing rules, the California law is indefinite and uncertain, and offers little protection to a physician who might be called to account before a court and jury, particularly if at the time there existed adverse public opinion.

## LETTERS†

### Concerning Letters of Appreciation from Station Hospitals of Military Camps in California for Medical Journals:

(COPY)

STATION HOSPITAL

Camp Callan

San Diego 14, California, June 11, 1945.

Postgraduate Committee,  
California Medical Association,  
San Francisco, California  
Attention: George H. Kress, M.D., Secretary  
Gentlemen:

We very much appreciate your sending CALIFORNIA AND WESTERN MEDICINE to our hospital, along with the other available medical literature you have indicated in your letter of June 5, 1945.

Small Station Hospitals are restricted in their Library funds and cannot always purchase the medical literature desired to keep the staff abreast of the times.

Sincerely yours,

(Signed) FRANK R. MADDISON,  
Major, MC, Post Surgeon.

INFIRMARY DIVISION

Mitchell Convalescent Hospital

Camp Lockett, California, June 7, 1945.

California Medical Association,  
San Francisco, California  
Attention: George H. Kress, M.D., Secretary

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Dear Doctor Kress:

Thank you for your letter of the 5th regarding the shipment of medical journals and books. They will be very gratefully received, for since this hospital is not numbered among the larger ones the supply of these items is rather limited.

Thank you also for the addresses of the three medical libraries: I know that we have men who will wish to make the most use of them.

Upon receipt of the package I will advise you.

Gratefully and fraternally yours,

(Signed) MERLE S. HARMON, Lt. Col. M. C.  
Director.

(COPY)

Army Service Forces

Ninth Service Command

FORT ORD ASF REGIONAL HOSPITAL

Office of the Commanding Officer

Fort Ord, California, June 12, 1945.

George H. Kress, M.D., Secretary  
C.M.A. Postgraduate Committee  
San Francisco, California

Dear Sir:

May I extend the appreciation and thanks of the medical staff of this ASF Regional Station Hospital for your generous contribution of medical magazines and journals.

It is with appreciation that we accept your offer of being included on your complimentary mailing list for the official publication of the California Medical Association, CALIFORNIA AND WESTERN MEDICINE. The staff members are being officially notified of the availability of medical literature at the addresses of the three medical libraries in California and will, I am sure, take full advantage of this offer.

On behalf of the medical members of the staff of this hospital, I wish to convey to our medical colleagues our sincere thanks.

Sincerely,

(Signed) J. I. SLOAT, Colonel, M.C.  
Commanding.

U. S. NAVAL HOSPITAL

Long Beach, California, June 12, 1945.

Postgraduate Committee,  
California Medical Association,  
San Francisco, California.

Dear Sirs:

We wish to thank you for placing us on the complimentary mailing list of your official journal, CALIFORNIA AND WESTERN MEDICINE, and for your contribution of an assortment of medical journals. These have been placed in the medical library for use by our staff.

With many thanks regarding your consideration for the medical officers of our hospital, I am

Cordially yours,

(Signed) C. W. WALTER, Lt. MC, U.S.N.R.  
Officer in charge of Medical Library.

(COPY)

AAF REGIONAL STATION HOSPITAL

Office of the Surgeon

Muroc Army Air Field

Muroc, California, June 8, 1945.

Dr. George H. Kress,  
Secretary, California Medical Association,  
Postgraduate Committee.

My dear Doctor:

Your letter of June 5 offering to send medical litera-

ture to this hospital arrived this morning. It has been posted on the bulletin board and is being enthusiastically read by all our Medical Officers.

Your periodicals have been, and will continue to be, a most welcome addition to the professional library of this hospital.

Please convey our appreciation to the members of your association.

Most sincerely,

(Signed) ROGER S. THOMPSON, *Lt. Col., M.C. Surgeon.*

#### Concerning a Letter from an Overseas Colleague on Proposed Sickness Insurance Laws:

(COPY)

U.S.S. MARVIN H. MCINTYRE (APA-129)  
c/o Fleet Post Office  
San Francisco, California

June 23, 1945.

George H. Kress, M.D., Secretary-Editor,  
San Francisco, California.

Dear Dr. Kress:

The excessive heat out here in enemy waters thousands of miles from home certainly militates against letter writing, but I simply must write to say that I think our California Medical Association is putting up a fine fight against State Medicine. During the time when we all tried so hard to pass the basic science law in California, I sent out five hundred letters and practically became a stump box orator, but now if I were home I think I would devote a full month to nothing but fight against the cancerous growth of medical socialism in our fine profession.

The pen is mightier than the sword so I plead with you and the other leaders in our fine State Medical Association to keep up their honorable fight for freedom of medical practice. Without such freedom, the miraculous progress of our profession will lose all of its stimulation and become merely a trade. It is unthinkable that medical brains can be placed on a business counter and purchased like butter and eggs. Then will come union labor in medicine. No thanks, I would prefer to be a hermit and go fishing. The fine conscientious medical reserve voluntarily gave up everything to help our nation retain her honor in the sun and I feel sure they appreciate deeply the struggle their hard working colleagues are doing at home to preserve their medical independence.

I feel that we need not worry if only the pedantically thorough medical profession deliver the true facts to the people.

We move around to so many different islands thousands of miles apart that mail has now become very difficult. However, when I hear from you I shall reply just as soon as work and port mail will permit. With every good wish to you and success to our fine California Medical Association in its fight against State Medicine.

Respectfully submitted,

(Signed) MERLYN GEORGE HENRY,  
*Lieut. Comdr., (MC), U.S.N.R.*

(Ed. Note.—With the above letter Doctor Henry sent several Japanese government peso bank notes and reprints of three interesting articles: (1.) Emergency Surgical Measures at an Advance Base; (2.) Chemical Burn of the Penis; and (3.) Complete Rupture of the Tendo Achillis.)

(COPY)

To the Editor:

Kindly change my mailing address to: Lt. Col. M. X.

Anderson, O-350073, Hq 85th Fighter Wing, A.P.O. 72, c/o Postmaster, San Francisco, Calif.

I have followed your articles on State and Federal Medicine with a great deal of interest and we feel that CALIFORNIA AND WESTERN MEDICINE has kept us informed as to the changes on the home front.

Thanking you for your kindness in changing my mailing address, I am

Sincerely yours,

(Signed) M. X. ANDERSON, *Lt. Col.*

#### Concerning Appreciation of Doctor W. H. Manwaring's Editorial Comment Articles:

(COPY)

THE UNIVERSITY OF TEXAS  
*The School of Medicine*

Galveston, Texas, May 8, 1945.

To the Editor: Congratulations on the continued success of your swell work for CALIFORNIA AND WESTERN MEDICINE. You can be very proud of the continued high character of your original contributions. Certainly Doctor Manwaring is doing a swell job for you on maintaining the high character of the editorial comments. I wish you could get some of the other boys to contribute. . . .

Faithfully yours,

(Signed) CHAUNCEY D. LEAKE, *Dean.*

#### Concerning Right to Selection of Physician in Workmen's Compensation Case:

(COPY)

PEART, BARATY & HASSARD  
*Attorneys at Law*  
One Eleven Sutter Street

San Francisco 4, California, June 18, 1945.

Humboldt County Medical Society  
Eureka, California  
Attention: Joseph S. Woolford, M.D.

Dear Doctor:

We have for attention, your letter of June 12 requesting advice on the right of an employee suffering an industrial injury to choose his own physician or surgeon.

Under the California Workmen's Compensation Act, as interpreted by the courts, the employer has the right in the first instance to designate and select the physicians who are to give treatment to injured employees. The workman is authorized to make his own selection at the expense of the employer only when the employer neglects or refuses to provide the necessary service, *Myer vs. Industrial Accident Commission*, 191 Cal. 673. The employer can exercise this right through his insurance carrier.

The Workmen's Compensation Act does provide, however, in Labor Code Section 4601, that an employee has a right to require one change of physicians, and in any serious case, a consulting physician. Labor Code Section 4601 reads as follows:

"Change of Physicians: Consulting physician, right to: Expense of treatment. If the employee so requests, the employer shall tender him one change of physicians and shall nominate at least three additional practicing physicians competent to treat the particular case, or as many as are available if three cannot reasonably be named, from among whom the employee may choose. The employee is also entitled, in any serious case, upon request, to the services of a consulting physician provided by the employer. All of such treatment shall be at the expense of the employer."

Under the law, then, the one remedy which an em-



ployee can exercise who is dissatisfied with the physician furnished in the first instance by his employer, is to request the employer for a change of physicians. In such event the employer is required to submit a change for the employee's choice, if physicians are available. In the event an employer refused to submit a change, it is our opinion that an employee could then go to a physician of his own choice, and if the treatment received was adequate and designed to effect a cure of the injury, the employer would be responsible for payment of its reasonable costs.

If you have any further inquiries along these lines, please feel free to call on us.

PEART, BARATY & HASSARD,

By Hartley F. Peart.

### Concerning Places Where Botulinus Antitoxin May be Obtained:

(COPY)

State of California

DEPARTMENT OF PUBLIC HEALTH

Sacramento, June 26, 1945.

Dear Dr. Kress:

This Bureau has recently published a revised list of places in this State where botulinus antitoxin is available. We are submitting a copy to you with the thought in mind that you might wish to consider it for inclusion in CALIFORNIA AND WESTERN MEDICINE.

We should appreciate receiving from you any suggestions that you might have as to the most practical methods of bringing this to the attention of California physicians.

Very truly yours,

RUSSELL FRANTZ, M.D.,

Chief, Bureau of

Acute Communicable Diseases.

1122 Phelan Building,

760 Market Street,

San Francisco 2, Calif.

### CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH

The places listed below are known to have botulinus antitoxin in stock as of June 22, 1945. This list may change from time to time.

#### COUNTY

##### Alameda

Alta Bates Hospital, Berkeley  
Berkeley General Hospital, Berkeley  
Cowell Memorial Hospital, Berkeley  
Oakland City Health Department

##### Butte

Bartlett Drug Store, Chico

##### Colusa

Colusa Memorial Hospital, Colusa

##### Contra Costa

County Health Department, Martinez  
Permanent Field Hospital, 14th and Cutting Blvd.,  
Richmond

##### Fresno

Fresno General Hospital, Fresno

##### Humboldt

County Health Department, Eureka

##### Imperial

County Health Dept., El Centro (available day and  
night at county jail)

##### Kern

Kimball and Stone Drug Store, Bakersfield  
Mercy Hospital, Bakersfield  
Kern County General Hospital, Bakersfield

##### Lake

Lakeport Drug Co., Lakeport  
Meddaugh's Drug Store, Lakeport

##### Lassen

Lassen County Hospital, Susanville

##### Los Angeles

Lederle Laboratory, 643 S. Olive Street, L. A.  
Jensen-Salsberg Laboratory, 1264 W. 2nd St., L. A.  
Horton & Converse L. A. depot  
Los Angeles General Hospital  
Stoner's Drug Store, 208 S. Market, Inglewood  
Titus Drug Store, 38 S. Garfield Street, Alhambra  
Pomona Valley Hospital, 1978 N. Garey  
Murphy Memorial Hospital, Whittier  
Santa Monica Hospital, 1250 16th Street  
St. Lukes Hospital, 2600 Washington Street, Pasadena  
San Pedro General Hospital, 1305 W. 6th Street, San  
Pedro

##### Madera

Madera Sanatorium, Madera  
Madera County Hospital, Madera  
County Health Department, Madera

##### Marin

Campion-Ward Prescription Pharmacy, 1350 4th Street,  
San Rafael

##### Modoc

Modoc County Hospital, Alturas

##### Monterey

Carmel Drug Store, Carmel

##### Napa

Victory Hospital, Napa  
St. Helena Sanitarium, St. Helena

##### Orange

Hardy's Drug Store, Fullerton

##### Riverside

County Health Department, Riverside  
Cotton's Drug Store, Riverside  
Riverside County Hospital, Arlington

##### Sacramento

Affleck Laboratories, 1008 10th Street, Sacramento  
Sacramento Hospital, Sacramento  
Willis & Martin Drug Co., Sacramento

##### San Bernardino

Professional Pharmacy, San Bernardino

##### San Diego

City and County Health Department

##### San Francisco

Central, Park, Alemany, and Harbor Emergency Hos-  
pitals  
Lederle Laboratory, 883 Mission Street  
San Francisco Hospital  
City Health Department, Bacteriological Laboratory  
State Department Public Health, 1122 Phelan Bldg.,  
760 Market Street

##### San Joaquin

County Health Department, Stockton

##### San Luis Obispo

County Health Department, San Luis Obispo

##### San Mateo

San Carlos Drug Store  
Community Hospital, San Mateo

##### Santa Barbara

Cottage Hospital, Santa Barbara  
County Health Dept., Court House, Santa Barbara

##### Santa Clara

County Hospital, San Jose  
O'Connor's Hospital, San Jose  
Palo Alto Hospital, Palo Alto

##### Shasta

Shasta Drug Co., Redding

##### Siskiyou

Avery Drug Co., Yreka

##### Solano

Vallejo Community Hospital, Vallejo

##### Sonoma

County Hospital, Santa Rosa  
County Health Department, Santa Rosa

##### Stanislaus

Model Pharmacy, Modesto  
Thornes Pharmacy, Modesto  
Kersten's Pharmacy, 806 F Street, Oakdale

##### Sutter

County Health Department, Marysville

##### Tulare

County Hospital, Visalia

##### Ventura

Brand's Pharmacy, Ventura

##### Yolo

Willis & Martin Drug Co., Sacramento

##### Yuba

County Health Department, Marysville

Megas (ca. 20 B. C.) was a surgeon who was born at Sidon in Phoenicia. He invented instruments for lithotomy.

## TWENTY-FIVE YEARS AGO†

### EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 7, July, 1920

EXCERPTS FROM EDITORIAL NOTES

*Public Health Convention at San Francisco, September 13-17.*—The 49th National Convention of the American Public Health Association will be held in San Francisco September 13-17, 1920, and from present indications will bring to California the most distinguished body of health officials that have ever come to the Pacific Coast. This is the first convention that the A.P.H.A. has held west of the Missouri River and for many of the delegates it will be the first visit to California. Our State has long boasted of its healthful attractions and has an opportunity now to exhibit them to scientific men and women who can appraise and appreciate them best. . . .

*Some Practical Features of Heart Disease.*—It has been said in these columns that modern medicine embraces the prevention, cure and alleviation of disease. In the realm of organic heart disease it is evident that prevention and cure have been little touched in our therapeutics, and what progress we have made has been chiefly in the line of alleviation, more or less lasting. The newer cardio-pathology takes less account of murmurs and cardiac sounds, and in turn stresses the functional ability of the heart as of chief value in prognosis and treatment. Excluding the relatively infrequent, acute, infective heart lesions, the treatment of heart disease therefore demands of the physician a better acquaintance with the first evidences of disease and a better knowledge of etiology, in order that the all-important prevention of heart disease may be more frequently accomplished. . . .

*Chiropractic S. O. S.*—We are informed by the Los Angeles Record that the chiropractors are issuing S.O.S. signals at frequent intervals these days. The signals are chiefly for quick and generous financial aid. Chiropractors who have been violating the medical practice laws have been arrested in a number of California cities. They want a defense fund.

The safest road for these to travel, as well as members of all other cults, and of the entire medical profession is the highway marked by definite statutes. It is not only safest for them but safest for the public. It is a mystery to us where and why any adult gets the opinion that the medical laws of this State can be violated with impunity. The amazing audacity of those who attempt to practice the healing art in defiance of law is born of egotism and ignorance. The exalted ego of little learning seems to convince its dupes that they are born to heal for coin and their ignorance confirms the verdict. . . .

#### EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

*From an Article on "Neglected Opportunities," by H. A. L. Ryfkoogel, M.D., San Francisco, Cal. Address of President.*—For many reasons the members of the medical profession of California are singularly fortunate. . . .

The possibilities of civic service by an organized medical profession. . . .  
(Continued in Front Advertising Section, on Page 28)

## BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.  
Secretary-Treasurer

### Board Proceedings

A regular meeting of the Board of Medical Examiners was held at Native Sons Hall, San Francisco, July 9th to 12th, at which charges of unprofessional conduct were heard, petitions for modification of probation and for restoration of revoked certificates were considered.

The next oral examination to be held by the Board is scheduled for August 11, 1945, at the Board's Los Angeles office, 907 State Building, Los Angeles. Applicants desiring to qualify for this examination should have fully completed applications on file at least two weeks prior to the date of the examination.

### News

"Army and Navy medical officers not holding California licenses, may treat military personnel outside of a military reservation or at a military hospital only in case of emergency and as an official duty to the armed forces, Attorney General Robert W. Kenny stated Saturday. His ruling was requested by the State Board of Medical Examiners. Kenny said, 'Army and Navy medical officers may in an emergency situation, treat the dependents of military personnel, since the health and welfare of such dependents bear directly upon the morale and efficiency of the members of the armed forces. Except in the case of such emergencies, and as an official duty, no medical treatment may be administered by unlicensed medical officers to non-military personnel in any non-Federal area within the State of California.' The opinion was prepared by J. Albert Hutchinson, Deputy attorney-general." (San Francisco Recorder, May 28, 1945.)

"The call was sounded today for more Los Angeles men and women to enlist in the United States Navy as Waves and Physicians. The reason for the urgent call, according to Vice Admiral Ross T. McIntire, surgeon general of the navy, is increased casualties expected in the Pacific war area. McIntire said that 10,000 more Waves and 4,000 physicians are needed by the navy immediately. Applicants may apply at the Office of Naval Procurement, 411 West Fifth Street." (Los Angeles Herald and Express, May 18, 1945.)

"'Tell the West Coast folks that we used blood five days after it was walking around in San Francisco. My buddies need more.' Lieutenant (jg) John R. Wassell sent that message to his father, the famed Dr. Wassell of Burma action fame. Lieutenant Wassell is a medical officer aboard a landing ship hospital. In the Iwo Jima campaign, he said, blood donated by San Franciscans was used in 37 major operations within a brief period. He said plasma had its place in surgery, but that it could not replace whole blood in extreme cases." (San Francisco News, May 19, 1945.)

"Paul O. Sampson, food faddist who addressed civic clubs of Chico, Oroville, Marysville, Gridley and dozens of other northern California cities on the subject of

(Continued in Back Advertising Section, on Page 44)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members. Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco 8.





## METAMUCIL

provides Smoothage in the treatment of constipation, protects the intestinal mucosa, induces a gentle, physiologic action.



Metamucil is the highly refined, non-irritating extract of a seed of the psyllium group, *Plantago ovata* (50%), combined with dextrose (50%). Metamucil is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois.

## SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

*Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature*



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If the drug or food product you are choosing should contain Vitamin D, this seal assures you that the strictest laboratory control possible is being exercised to guarantee that the "Sunshine Vitamin" is there in full strength—for every product bearing this seal is rigorously tested in the Foundation laboratories.

For twenty years this Foundation has carried on its program of research and testing. It licenses only products of definite value. That is why the Foundation seal has won the complete confidence of the medical profession and the public. Look to it for your added guarantee.

**WISCONSIN ALUMNI *Research* FOUNDATION**  
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# For HERNIA

## If Inoperable - Or When Operation Is To Be Delayed

### A SPENCER

#### Will Give Safe, Comfortable Support

Non-elastic. Will not yield under strain. No leather, metal or hard pads.

The reason why Spencer Supports are so effective is this: Each Spencer Support is individually designed at our New Haven Plant *after* a description of the patient's body and posture has been recorded—and 15 or more measurements have been taken. This assures the doctor that each patient will receive the proper design to aid his treatment; that the support will improve body mechanics and will fit with the precision and comfort necessary. Yet a Spencer costs little or no more than an ordinary support.

*At left:*

Spencer Abdominal Supporting Belts designed especially for man and woman pictured. Non-elastic. Instantly adjusted. Can not yield or slip. The weight of support is placed on the pelvic girdle, not on spine at or above lumbar region.

#### After Herniotomy

As a protection for the weakened abdominal wall, especially when patient is forced to return to work sooner than the doctor desires, a Spencer is helpful. Each Spencer is so designed as to permit exercise of abdominal muscles while providing adequate back and abdominal support.

For further information, look in telephone book under Spencer corsetiere or write direct to us.

# SPENCER

**INDIVIDUALLY  
DESIGNED**

## Abdominal, Back and Breast Supports

SPENCERS  
are also  
Individually  
Designed  
for . . .

Fractured Vertebrae  
Protruding Disc  
Spondylolisthesis  
Spondylarthritis  
Sacroiliac or  
Lumbosacral Sprain  
Kyphosis                      Lordosis  
Scoliosis  
Osteoporosis  
Visceroptosis or  
Nephroptosis  
with Symptoms  
Prenatal-Postpartum  
Needs  
Obesity  
Postural Syndrome

And for Patients  
Following . . .

Hysterectomy  
Nephropexy  
Nephrectomy  
Cholecystectomy  
Colostomy  
Cesarean Section  
Spinal Surgery  
Breast Supports  
are also  
Individually  
Designed for . . .

Poised Breasts  
Mastitis                      Prenatal  
Nodules                      Nursing  
Prolapsed and  
Atrophic Breasts  
Stasis in Breast Tissues  
Following Breast Removal

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## The Troublesome Symptoms of the Climacteric *relieved with*

A new synthetic compound — not derived from the stilbenes—with marked estrogenic properties, Schieffelin Benzestrol appears to satisfy all requirements for a satisfactory estrogen.

Active, effective and well tolerated, whether administered orally or parenterally, Schieffelin Benzestrol furnishes an economical means of relieving the distressing symptoms that are characteristic of the menopause.

**Schieffelin  
BENZESTROL**  
(2, 4-di (p-hydroxyphenyl)-3-ethyl hexane)

**Schieffelin Benzestrol Tablets:**

Potencies 0.5, 1.0, 2.0, 5.0 mg.  
Bottles of 50, 100, 1000.

**Schieffelin Benzestrol Solution:**

Potency of 5.0 mg. per cc.  
Rubber capped multiple dose vial.

**Schieffelin Benzestrol Vaginal Tablets:**

Potency of 0.5 mg.  
Bottles of 100.

*Literature and Sample on Request*

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### Las Encinas Sanitarium . . . . . Pasadena, California

INTERNAL MEDICINE INCLUDING FUNCTIONAL AND ORGANIC NERVOUS SYSTEM DISEASES

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Address: STEPHEN SMITH, M.D., F.A.C.P.; CHARLES W. THOMPSON, M.D., F.A.C.P.

Medical Directors, Pasadena, California

### TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 28)

information to warrant us in recommending their defeat.

*What Anti-Vivisection Would Do to California:*—The first to which I invite your attention is the proposed initiative which the anti-vivisectionists are placing on the ballot to be voted on at the general election, November 2, 1920. . . .

*Why Do Chiropractors Want Independent Board?:*—The second measure is the Chiropractic Initiative which proposes to create a separate Board of Chiropractic Examiners. Under the present laws of California a chiropractor may take the drugless examination which requires only half the educational qualifications demanded for a physician and surgeon's certificate. So that any half-educated disciple of chiropractic may secure a license by passing the easy examination given by the State

Board of Medical Examiners. . . .

*Osteopathic Referendum:*—Another measure on which the medical profession should be prepared to give accurate information is the referendum which the osteopaths have placed upon Senate Bill No. 604. Senate Bill No. 604 amends Sections 7, 8 and 9 of the Act of March 6, 1907, regulating the sale and use of poisons in the State of California, and makes it unlawful for any person to sell, vend, or give away or furnish a hypodermic needle unless such instrument was purchased by a duly licensed physician, dentist or veterinarian to practice and prescribe medicine. All these various terms are defined in the Act and do not include an osteopath. . . .

*Constitutional Amendment Proposed by the Public School Protective League:*—A fourth measure—a Constitutional Amendment—will appear on the ballot at the general election November 2, 1920. . . .

*Better Health Magazine:*—*Better Health* magazine—

(Continued on Page 40)



# Penicillin

## DOSAGE TABLE\*

INDICATIONS	INITIAL DOSE (UNITS)	CONTINUING DOSAGE (UNITS)	UNITS IN 24 HR.	REMARKS
<b>Serious Infections</b> (staphylococcus, clostridium, hemolytic streptococcus, anaerobic streptococcus, pneumococcus, gonococcus, anthrax, meningococcus) Adults and children	15,000 to 20,000	(a) Intravenous drip: 2000 to 5000 every hr.	40,000 to 120,000 or more	(a) Dissolve ½ of 24 hr. dose in 1 liter (1000 cc.) normal saline; let drip at 30 to 40 drops per minute.
		or (b) Intramuscularly: 10,000 to 20,000 every 3 or 4 hr.	40,000 to 120,000 or more	(b) Concentration: 5000 U. per cc. normal saline.
		or (c) Intramuscular drip	40,000 to 120,000 or more	(c) Total daily dose in 250 cc. normal saline.
Infants	5000 to 10,000	3000 to 10,000 intramuscularly every 3 hr.	20,000 to 40,000 or more	Each dose in 1 or 2 cc. of normal saline.
<b>Chronically infected</b> compound injuries, osteomyelitis, etc. Adults and children	5000 to 10,000	10,000 every 2 hr. or 20,000 every 4 hr. intramuscularly or intravenously. Larger doses may be necessary at times.	40,000 to 120,000 or more	Concentration for intramuscular inj.: 5000 U. per cc. normal saline. For intravenous inj.: 1000 to 5000 U. per cc. Supplement with local treatment.
<b>Gonorrhea</b>	20,000 every 3 hr. intramuscularly for 5 doses		100,000	Results of treatment should be controlled by culture of exudate.
<b>Empyema</b> Adults and children	30,000 to 40,000 once or twice daily into empyema cavity		30,000 to 80,000	Dissolve in 20 to 40 cc. normal saline and inject into empyema cavity after aspiration of pus.
<b>Meningitis</b> Adults and children	10,000 once or twice daily into subarachnoid space or intracisternally		10,000 to 20,000	Concentration: 1000 U. per cc. normal saline.
<b>Bacterial Endocarditis</b> Adults and children	25,000 to 40,000	25,000 to 40,000 every 3 hr. intramuscularly	200,000 to 300,000	Continuous treatment for 3 weeks or longer. In a few cases the intravenous drip is more advantageous.

\*Based upon recommendations by Chester S. Keefer, War Production Board Penicillin Leaflet, Apr. 1, 1945; and by Wallace E. Herrell and Roger L. J. Kennedy, *Journal of Pediatrics*, 25:505, Dec., 1944.

● Write for pocket size copies of this Dosage Table

Penicillin Sodium-Winthrop is available in vials (with rubber diaphragm stopper) of 100,000 Oxford Units.



WINTHROP CHEMICAL COMPANY, INC.

*Pharmaceuticals of merit for the physician*

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# Colfax School for the Tuberculous

COLFAX, CALIFORNIA

There are two units, The Colfax Hospital and the Bushnell Sanatorium, for the treatment of Pulmonary Tuberculosis.

The Colfax School for the Tuberculous is located in the pine clad Sierra Nevada foothills, at an elevation of 2,400 feet; an elevation free from the fogs of the valleys and free from extremes of heat or cold.

This Institution supplies, among other advantages:

1. Individual care and supervision under skilled physicians.
2. Education as to essentials of recovery from, and the prevention of the spread of, disease.
3. Complete laboratory and x-ray equipment.
4. Every proved method of treatment, including pneumothorax and phrenic nerve interruption. (Major thoracic surgery referred to skilled thoracic surgeons.)
5. An absence of institutional atmosphere.
6. Reasonable rates.

• • •

For further information  
write

**ROBERT A. PEERS, M.D.**  
Medical Director  
COLFAX, CALIFORNIA

• • •

**F. LYNN SMITH, M.D.**  
Consultant in General Medicine

**F. HARRY BENTEEN, M.D.**  
Consultant in General Surgery

**EMILE HOLMAN, M.D.**  
(Stanford Hospital),  
Consultant, Thoracic Surgery



Dexokol Capsules are professionally designed and packaged especially for prescription use.

## CAPSULES DEXOKOL INGRAM

This product is one that is meeting with much approval because, in addition to having the feature of high-potency Vitamin D, we have added to DEXOKOL capsules purified bile acid salt which greatly aids in absorption of the fat soluble Vitamin D.

### EACH CAPSULE CONTAINS

Vitamin D	50,000 i/u
Dehydrocholic Acid	1/3 grain
B Complex of:	
Thiamine HC <sub>1</sub>	1 mgm
Riboflavin	2 mgms
and Other Factors Natural to Yeast	

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*William E. Costolow, M.D.	D. C. Lord, M.D.
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Ina Gourley, M.D., Oakland

### TWENTY-FIVE YEARS AGO

(Continued from Page 36)

the official organ of the League for the Conservation of Public Health—will deal very fully in coming issues with this and other vital issues that confront the medical profession. . . .

*From an Article on "Experiences in Testicle Transplantation," by L. L. Stanley, M.D., San Quentin, Cal.—*During the past two years eleven men have been operated upon at San Quentin prison for the implantation of human testes taken from recently executed convicts.

In the past four months, twenty-one have had implanted in them testicular material taken from young rams.

This work was done to substantiate, or disprove the assertions and claims made by various writers, particu-

larly Lydston of Chicago, whose reports have appeared in medical journals, and later by Voronoff of Paris, and Brinckley of Milford, Kansas, who through the daily press under their own signatures have made statements which have aroused the curiosity of the public and have instilled into some unfortunates, the hope of longevity and eternal youth. . . .

*From an Article on "Uretero-Pyelography and Cystography: Their Present Status and Safety as Diagnostic Agents," by George G. Reinle and E. Spence DePuy, M.D., Oakland, Cal.—*Since, through the injection of shadow-casting material into the ureters, kidney pelvis and calyces it has become possible to obtain silhouettes of this portion of the urinary tract, the question naturally arises as to whether the results obtained from this procedure are of scientific value. And as we are

(Continued on Page 42)

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Natural and healthy childhood exuberance may be limited to anal pathology not demonstrable by anal stricture but nevertheless incapacitating and conducive to lethargy, nervousness and insomnia. Muscle tone greater than normal, especially in association with an atonic colon, is often reduced by mechanical dilation with YOUNG'S DILATORS.

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YOUNG'S DILATORS in children's small and intermediate sizes, sold on prescription only, are available in bakelite; boilable and easily inserted by parent or nurse. Postoperative use of YOUNG'S DILATORS after pediatric anal surgery to relieve stenosis and atresia of the anus and rectum is also recommended by pediatricians and proctologists. Children's set of 4 sizes \$4.50. Adult set of 4 sizes \$3.75. Available at ethical drug stores or your surgical supply house. Literature sent on request.

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*For interesting information on these subjects, we refer you to two articles, "Nutritional Aspects of Beer" and "Vitamins in Beer" in the September and December, 1944, issues of The American Brewer.*

Again in 1944, ACME increased its lead in sales over all other California beers, as it has done each year since Repeal. This continuing popularity means simply that more and more people are saying, "I'll take ACME!"



ACME BREWERIES • San Francisco • Los Angeles



## TWENTY-FIVE YEARS AGO

(Continued from Page 40)

also, through use of the same media enabled to obtain shadow pictures of bladder outlines, whether this is of any importance to us? If uretero-pyelography and cystography are of assistance to us in making a diagnosis and forecasting an outcome it is of moment whether the information obtained through these procedures has been acquired through peril to either the patient's life or even delay of his return to a normal condition. . . .

*Excerpts from Minutes of the House of Delegates—The Forty-ninth Annual Session of the Medical Society of the State of California: First Session Held at The Ambassador, Santa Barbara, Tuesday Evening, May 11, 1920, 8:30 o'clock:*

*Report of the Council.*—The President then called upon the Chairman, C. G. Kenyon, who read the following report of the Council:  
To the President and the Members of the House of Delegates:

As Chairman of the Council, I wish to present the following report:

During the year 1919-1920 the Council has met upon seven occasions. The majority of these meetings were called to consider the subject of the *Industrial Accident Insurance*. The committee which had this work in charge has labored most strenuously and done more actual work than any one not familiar with the situation could realize. The Council has summed up the work of this committee, and this matter will be presented to you in proper form later on. It must be stated, however, that the fee schedule problem is one having many angles and very difficult to solve. The results of our deliberations

can only be termed a compromise report. It is a step in the right direction and we can only make one step at a time. An effort of this sort will bring good results and more good to the profession at large than any sporadic and ill-considered action on the part of isolated units in the Medical Society. We therefore ask you to have patience and promise that the Council, if authorized, will continue its activity on behalf of the practicing profession. . . .

*Report of the Secretary.*—The President then called upon the Secretary, Saxton Pope, who made the following report: . . .

Through our efforts to gain new members last year we have increased our membership to 2879. This work goes on and it shall be continued during the coming year until we shall undoubtedly exceed the total number of 3000 physicians in the State. . . .

*Unfinished Business: Adoption of the Report of the Committee on Industrial Accident Work.*—The President then called upon Jas. H. Parkinson, Chairman of the Committee appointed by the Council, for a final report of the work which had been accomplished by said Committee in Industrial Accident work. . . .

*Fee Schedule for Physicians and Surgeons.*—Presented by the Committee of the Council of the Medical Society of the State of California for the treatment of Industrial Accident cases covered by the Workmen's Compensation Law. Note A. These fees represent a minimum! Fees higher than schedule will be allowed when warranted by unusual difficulties or requiring an unusual amount of time. . . .

*Second Session, Wednesday Evening, May 12, 1920, at 8:30 o'clock.*—*Election of Officers.*—Nominations for President-Elect were declared in order.

*President-Elect.*—John H. Graves of San Francisco

(Continued on Page 44)

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**T**he greatest skill in any field is but outward evidence of the highest measure of control.

It follows naturally, therefore, that the modernly equipped U. D. laboratories should operate under one of the most stringent and efficient systems of quality control employed in the production of fine pharmaceuticals. Based on practical experience, and developed over a long period of years, this system is supervised by the competent Formula Control Committee of doctors, chemists and pharmacists. Notwithstanding all the earlier safety measures applied in the development process, every formula

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PHARMACEUTICAL CHEMISTS FOR MORE THAN 42 YEARS  
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• The Cottage Department (for mental patients) has its own facilities for hydropathic and other treatments. It consists of small cottages with homelike surroundings, permitting the segregation of patients in accordance with the type of psychosis. Also bungalows for individual patients, offering the highest class of accommodations with privacy and comfort.

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3. A resident medical staff. A large and well-trained nursing staff so that each patient is given careful individual attention.

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Intensive full-time instruction in those subjects which are of particular interest to the physician in general practice. The course covers all branches of Medicine and Surgery.

### ADVANCED OTOTOLOGY

A special course in advanced otology including cadaver operative instruction, the recently advocated surgery for petrositis, meningitis, surgery for improvement of defective hearing (otosclerosis), attendance at clinics and lectures, examination of patients pre-operatively, witnessing operations, follow-up post-operatively in the wards.

For Information Address: MEDICAL EXECUTIVE OFFICER, 345 West 50th Street, New York, 19

## TWENTY-FIVE YEARS AGO

(Continued from Page 42)

was nominated for President-Elect by Frank B. Carpenter of San Francisco, said nomination being duly seconded by Wm. T. McArthur of Los Angeles. On motion, duly seconded, the Secretary was instructed to cast the ballot of the House for John H. Graves for President-Elect. The Secretary duly cast the ballot, and John H. Graves was duly declared elected President-Elect of the Society for the year 1920. . . .

Driven from every other corner of the earth, freedom of thought and the right of private judgment in matters of conscience directed their course to this happy country as their last asylum.

—Samuel Adams, *Speech*, Philadelphia, 1 Aug., 1776.

## BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 54)

better and longer living through diet, was arrested yesterday and booked at the Chico City Jail on four charges of violating the medical laws and the pure food laws of California. Held on \$2,000 bail on the four charges, he was finally released on personal recognizance to his attorney, Allison Ware, by order of Justice of Peace S. P. Robbins. He was arrested by Joseph W. Williams, . . . special agent of the State Medical Board, and L. F. Gipson, investigator of the State Pharmacy Board. Sampson was specifically charged with violating section 2141 of the Medical Laws business and professional code for practicing a system of treating the sick without a license . . ." (*Chico Record*, May 6, 1945.)

(Continued on Page 46)





## ERYSIPELOID

(Rosenbach's Disease)

Not to be confused with streptococcic erysipelas, this extremely painful, and sometimes even fatal infection is caused by *Erysipelothrix rhusiopathiae*. It is observed rather frequently among those brought into contact with animals and fish.

Veterinarians, slaughterhouse-workers, butchers, farmers, bone-button makers, fish-handlers and cooks are most likely to contract the condition, which usually starts as an erythema at the site of primary infection, notably the fingers.

### Now—WELL-TOLERATED TREATMENT WITH *Concentrated* ANTI-ERYSIPELOID SERUM (PITMAN-MOORE)

#### HOW SUPPLIED

Pitman-Moore Concentrated Anti-Erysipeloid Serum is available in 10 cc. vials. Two to five cc. is usually adequate for the initial dose. In some instances repeated or increased dosage will not be necessary.

Since the disease in animals responds to sero-therapy, the unrefined anti-swine erysipelas serum was employed in human cases, with much success. However, this unconcentrated serum, in effective dosage, leads rather frequently to anaphylaxis and serum reactions.

**REDUCED REACTIONS**—To minimize this objection, Pitman-Moore Laboratories have developed a *concentrated* and *refined* anti-serum for human use, in which the volume is reduced as much as 80%.



*Complete information to physicians on request.*



**PITMAN-MOORE COMPANY**



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CALIFORNIA



A general hospital of 225 beds operating an accredited School of Nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and operated by the French Mutual Benevolent Society through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons.

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Fully equipped for the diagnosis and modern treatment of diseases of the chest, including tuberculosis and other respiratory diseases

**BELMONT, CALIFORNIA**

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**LEE S. SANELLA, M. D.**  
*Resident Clinicians*

## BOARD OF MEDICAL EXAMINERS

(Continued from Page 44)

"Taken into custody while free on bail on two similar counts, Dr. Samuel D. Collins, 42, a chiropractor, of 516 S. Commonwealth Ave., was held today on suspicion of performing an illegal operation. His asserted victim, Lelai Drabic, 22, of 808 S. Hartford St., was in a serious condition in General Hospital. She assertedly told police she paid Collins \$100.00 to perform the operation May 18." (*Hollywood Citizen-News*, May 22, 1945.)

"More than a hundred San Quentin prisoners, called upon to assist the Government in its fight against dread bubonic plague, have volunteered as guinea pigs. Fifty selected men were inoculated with a new vaccine produced at Hooper Foundation of the University of Cali-

fornia under a research program sponsored by the Office of Scientific Research and Development. . . . The prisoners were asked to join in the fight after thirty Hamilton Field volunteers were transferred to combat duty before reaction of the vaccine could be tabulated. . . . It was explained to the prisoners that the principal purpose of the Government-sponsored research was to develop immunization to plague without inconvenience to those vaccinated. Scientists have been working for years to develop a vaccine which could be administered without ill effects. Bubonic plague is now endemic in ground squirrels in the western states and among rats in the Bay Area. . . ." (*San Francisco Chronicle*, May 25, 1945.)

We [in America] set out to Oppose Tyranny in all its Strides, and I hope we shall persevere.

—Abraham Clark, *Letter to John Hart*, 8 Feb., 1777.

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For the underweight patient just recovered from severe acute or chronic illness, increase in weight may be difficult to achieve with the customary high-caloric diet. Yet restoration of normal fat deposits and correction of nutritional deficiencies are essential for rapid return of strength and resistance to infection.

The intake of essential nutrients high in calorific value is expeditiously accomplished by including Ovaltine in the diet. This tasty food drink, made with milk as directed, is

enjoyed by all patients both as a mealtime beverage and between meals. Not only rich in calories, it also provides generously other nutrients urgently required: biologically adequate proteins, highly emulsified fat, B complex and other vitamins, as well as the essential minerals iron, copper, calcium, and phosphorus. The low curd tension of Ovaltine favors quicker gastric emptying, hence the appetite actually tends to become enhanced through this desirable behavior.

**THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.**



# *Ovaltine*

Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,\* provide:

PROTEIN . . . . .	31.2 Gm.	VITAMIN A . . . . .	2953 I.U.
CARBOHYDRATE . . . . .	62.43 Gm.	VITAMIN D . . . . .	480 I.U.
FAT . . . . .	29.34 Gm.	THIAMINE . . . . .	1.296 mg.
CALCIUM . . . . .	1.104 Gm.	RIBOFLAVIN . . . . .	1.278 mg.
PHOSPHORUS . . . . .	.903 Gm.	NIACIN . . . . .	7.0 mg.
IRON . . . . .	11.94 mg.	COPPER . . . . .	.5 mg.

\*Based on average reported values for milk.



## EPINEPHRINE HYDROCHLORIDE 1:1000 N.N.R.

CHEPLIN solution of this powerful vasoconstrictor, hemostatic and circulatory stimulant is adjusted to a definite standard strength and is physiologically assayed by measuring the effect on blood pressure.

EPINEPHRINE HYDROCHLORIDE may be administered by hypodermic, inhalation or topical application, affording rapid relief of asthmatic symptoms, urticaria, angioneurotic edema, reactions following injections of biologicals, shock or collapse, and prompt control of certain types of hemorrhage. When used in conjunction with topical, nerve block or infiltration anesthetics, it produces a bloodless operative field and retards absorption of the anesthetic—thus prolonging the period of anesthesia.

*Literature on request*

EPINEPHRINE HYDROCHLORIDE 1:1000 is packaged in:

- 1 cc. ampules.
- 10 cc. rubber-stoppered vials.
- 30 cc. rubber-stoppered vials.
- 30 cc. bottles for topical application.



# CHEPLIN

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SYRACUSE 1, NEW YORK





## Why We Do Not Advertise to the Laity

- The confusion resulting from the increased laity advertising of vitamin fortified evaporated milks has further strengthened our belief that all therapeutic and infant feeding information should be disseminated only by the medical profession. Special Morning Milk is the only vitamin fortified evaporated milk in the West that is not advertised to the laity.

*Special Morning Milk is fortified with 400 U.S.P. units vitamin D and 2000 U.S.P. units vitamin A (from the natural source) per reconstituted quart.*



*Special* MORNING MILK

*Ethically Promoted*

# THE TABLET METHOD FOR DETECTING URINE-SUGAR CLINITEST

offers these advantages to physician, laboratory technician, patient:

## ELIMINATES

Use of flame  
Bulky apparatus  
Measuring of reagents

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Simplicity  
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Convenience of technic.

Simply drop one Clinitest Tablet into test tube containing proper amount of diluted urine. Allow time for reaction, compare with color scale.

## FOR OFFICE USE

Clinitest Laboratory Outfit (No. 2108) Includes—Tablets for 180 tests, test tubes, rack, droppers, color scale, instructions. Additional tablets can be purchased as required.

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Clinitest Plastic Pocket-Size Set (No. 2106) Includes—All essentials for testing—in a small, durable, pocket-size case of Tenite plastic.



Order  
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ELKHART INDIANA

## Need for 16-Year-Minimum-Age Employment Standard Pointed Up By Large Number of 14- and 15-Year-Olds Now in Labor Force

Close to a million 14- and 15-year-old boys and girls, approximately one out of five in that age group in the population, are in today's labor force either as full- or part-time workers. Of that number a quarter of a million have left school altogether.

The increase in employment in this age group is proportionately greater than for the 16- and 17-year-old workers, whose numbers are also large, some 2,000,000 being at work.

These estimates, based upon a recent Census sampling, point up the wartime reversal of a long-time trend away from employment for children under 16, with more and more of them in school their full time.

Many of these young boys and girls are putting in long hours of work; hours that in some cases would be considered unduly long for an adult. The Census sampling disclosed that of the 14- and 15-year-olds out of school, almost three-fifths were working more than 40 hours a week, or beyond the maximum recommended for children of those ages. In fact, over one-third were reported as working more than 48 hours a week. Of the student group, three-fourths had a combined work and school program of more than 40 hours a week. Two-fifths of the group were putting in more than 48 hours, and 17 per cent, 56 hours or more per week in school and on the job.

Large numbers of these boys and girls, both the in-school group and the others, were employed in agriculture, and some were working as domestics, work carried on without much of the legislative protection provided for minors in other occupations.

## Transfusion Malaria

The increasing danger of transmission of malaria by means of blood transfusion was forcibly brought to the attention of the Department of Health of the City of Los Angeles recently by a report of such a case occurring in one of the larger hospitals of that city. The patient had had 28 blood transfusions over a period of 3 months, for bleeding peptic ulcer. Some of the donors were army personnel, one at least from the South Pacific. They are all being investigated at the present time.

Woolsey, in 1910, described the transmission of malaria to a patient with pernicious anemia by means of a blood transfusion. Many other investigators have subsequently described this phenomenon. Wang and Lee in 3,700 transfusions at Peking Union Medical College, from 1925 to 1935, reported 54 cases of benign tertian malaria. This is an incidence in a malarious area of 1.4 per cent.

The infection may be latent in the donor for years and still be transmissible. Naviero, some years ago, reported a case of malaria developing from a donor who had been symptomless for 37 years. Even the storage of blood at low temperatures for weeks will not kill the plasmodium, nor will the addition of quinine to the blood prior to transfusion prevent transmission of the infection. The incubation period of transfusion malaria varies from one to sixty days, but is usually one to four weeks.

Other diseases transmitted by blood transfusions include syphilis, measles, influenza, relapsing fever, smallpox, septicemia, typhoid fever, and gonorrhea.

All blood donors should be carefully questioned concerning history of, or exposure to malaria. Blood from donors who have been in a malarious region should be excluded or converted into plasma.





24 HRS.

18 HRS.

12 HRS.

6 HRS.

Quick acting  
INSULIN

Intermediate  
acting  
GLOBIN  
INSULIN

Action carries over beyond 24 hrs

Delayed acting  
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## Consider all 3 insulins for better diabetes control...

THE physician now has three types of insulin available to treat diabetes. One is quick-acting but short-lived. Another is slow-acting but long-lived. The new third one—'Wellcome' Globin Insulin with Zinc—is intermediate.

Action with Globin Insulin begins moderately quickly and persists for sixteen or more hours, sufficient to cover the period of maximum carbohydrate intake. By night, activity is sufficiently diminished so that the likelihood of nocturnal reactions is minimized. A single injection daily of 'Wellcome' Globin Insulin with Zinc will control the hyperglycemia of many diabetics. When a diabetic requires insulin therapy, the physician is wise to consider all three insulin types.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc.

'Wellcome' Trademark Registered



'WELLCOME'  
*Globin* / *Insulin*  
WITH ZINC



Literature on request.

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*Lenses*

Active war work has brought you hundreds of older people who want youthful vision. When your carefully-analyzed bifocal prescriptions are translated in lenses of the famous Orthogon and Panoptik series, your patients get the full benefit of corrected curves from edge-to-edge—in the vital marginal areas. That's why the increased supply of Orthogon and Panoptik bifocal lenses still does not always meet the demand.

*In Soft-Lite, too.*



**RIGGS OPTICAL COMPANY**

**distributors of BAUSCH & LOMB products**

**Buy War Bonds**

## THE POTTENGER SANATORIUM and CLINIC

*For Diseases of the Chest*

*Monrovia, California*

**AN INSTITUTION FOR DIAGNOSIS AND THERAPY**

(Established 1908)

**C**HOICE rooms and bungalows. Rates moderate and include routine medical and nursing services. Interim physical, X-ray and laboratory examinations, ordinary medicines and pneumothorax. A charge is made for the first complete examination.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases. Separate institution for children.

For particulars address:

**THE POTTENGER SANATORIUM AND CLINIC • Monrovia, California**

### Academy of Pediatrics Proposes Health Survey as Basis for Post-War Services to Mothers and Children

A survey of the Nation's children in terms of what is available and what is needed in the way of health services for their care has been proposed by the American Academy of Pediatrics as a prelude to planning effectively for the next few years.

In substance, the request is that the Children's Bureau and the U. S. Public Health Service cooperate with the Academy in making a State by State survey to gather information concerning the present situation and the personnel and facilities that would be needed to "make available to all mothers and children in the United States all essential preventive, diagnostic, and curative health services."

Although infant death rates for the Nation are now

at the lowest level ever reported for the country—only 1 in 25 babies dies before the end of the first year of life—wide variations exists by states and by population groups. In one state, 1 baby out of 10 is lost; in another, 1 out of 30. The death rate for negro infants is 72 per cent higher than that for white infants.

### Causes of Maternal Deaths

In 1934 the maternal death rate was 5.9 per 1,000 live births. The chief causes of death were divided as follows:

Infection—39.2 per cent.

Toxemia—23.5 per cent.

All others—37.3 per cent.

In 1943 the maternal death rate was 2.5 per 1,000 live births, with the chief causes of death: infection 36.4 per cent, toxemia 26.4 per cent and all others 37.2 per cent.

(Continued on Page 54)

*Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature*



# "What are the MAGIC WORDS?"

No magic words, no magic wand can improve a cigarette.  
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\* Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154  
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60



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### CAUSES OF MATERNAL DEATHS

(Continued from Page 52)

About 17 per cent of all these maternal deaths were associated with abortions. These were scattered among the three chief causes of death. About 15 per cent occurred before delivery and 63 per cent during or after childbirth. —Maternity Center Association "Briefs."

#### Los Angeles Health in 1944

Dr. George M. Uhl, City Health Officer of Los Angeles, has issued the following report on health conditions in Los Angeles during 1944:

"At 1944's end, Los Angeles was running a temperature, but it could hardly be said to have had a high-grade fever. The city had passed its third war year bulging with an over-crowded population, and it had been hit by a few wartime diseases, none of which reached epidemic proportions. Its health, while good, was far from perfect.

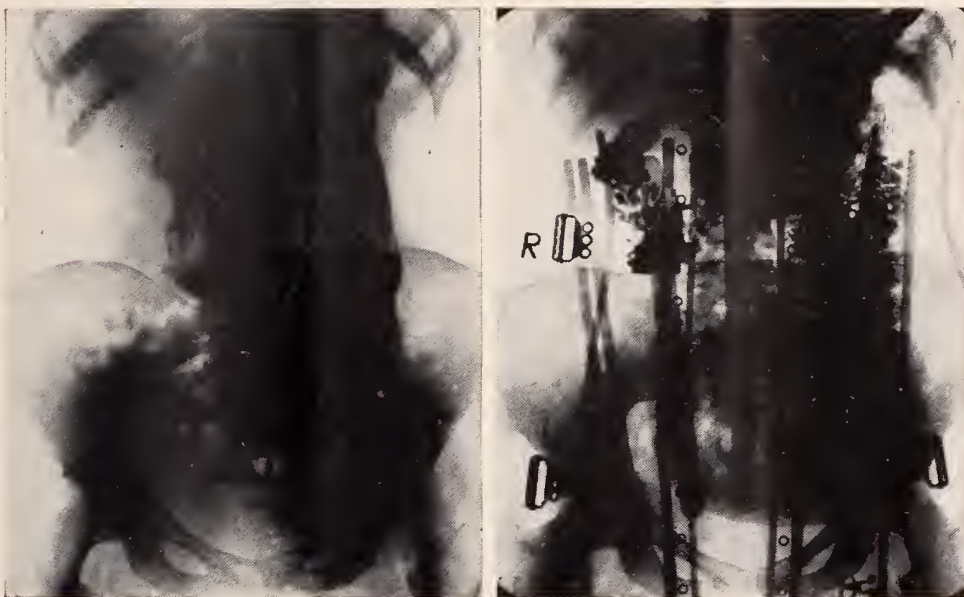
"Once again, with extraordinary coöperation from the community, major health emergencies had been averted. For a need which the U. S. Public Health Service said was \$2,000,000, the city had frugally spent \$900,000. Sorely needed to tackle critical problems were equipment, facilities, and personnel.

"The city had closed its purse to many exigencies, but for every Health Department dollar it spent it had driven a good bargain. It managed to keep its milk supply pure through inspections in 1,400 dairies and milk stations as far as 300 miles from Los Angeles. It maintained safe conduct for food in 8,000 bakeries, dairies, restaurants, and 3,000 markets. It kept a watchful eye on health conditions in 900 industries, 15,000 hotels and

(Continued on Page 55)



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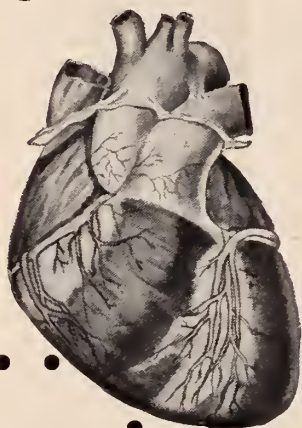
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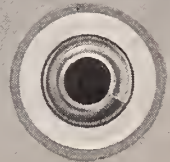
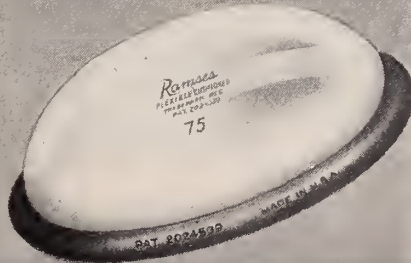
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### LOS ANGELES HEALTH IN 1944

(Continued from Page 52)

apartments, 4,000 barber shops and miscellaneous businesses, and 100 poultry and rabbit abattoirs. It pushed some diseases downward and kept others from skyrocketing by making 85,000 home calls, giving 300,000 treatments, and having full coöperation from the medical profession.

"To do all this, the department placed its 426 employees where they could least be spared, dropped less pressing issues, asked and got public support. Los Angeles' aches were familiar ones.

"Again in 1944, tuberculosis, with 966 deaths, was second only to accidents in the toll of human life under 45 years of age, but its mortality rate had dropped two-thirds in the last quarter century. Meanwhile, although

operating one of the largest ambulatory pneumothorax clinics in the country, the department could not accommodate all who came for tubercular care.

"Syphilis, with nearly 12,000 cases, led all other communicable diseases, its reported number still climbing as public awareness led to greater search for it. Venereal disease clinics, handling 200,000 patient-visits in the busiest year of their history, looked forward to the relief that would come with expanded postwar facilities.

"Diseases which spread with crowding made stubborn advances, the most serious threat coming from diphtheria, which struck more victims and took more lives in Los Angeles than in any other large American city. Its 330 cases and 23 deaths had reached what is hoped to be the crest of a wave that started in 1942, when war crowding began to revive the disease after it had almost been obliterated here.

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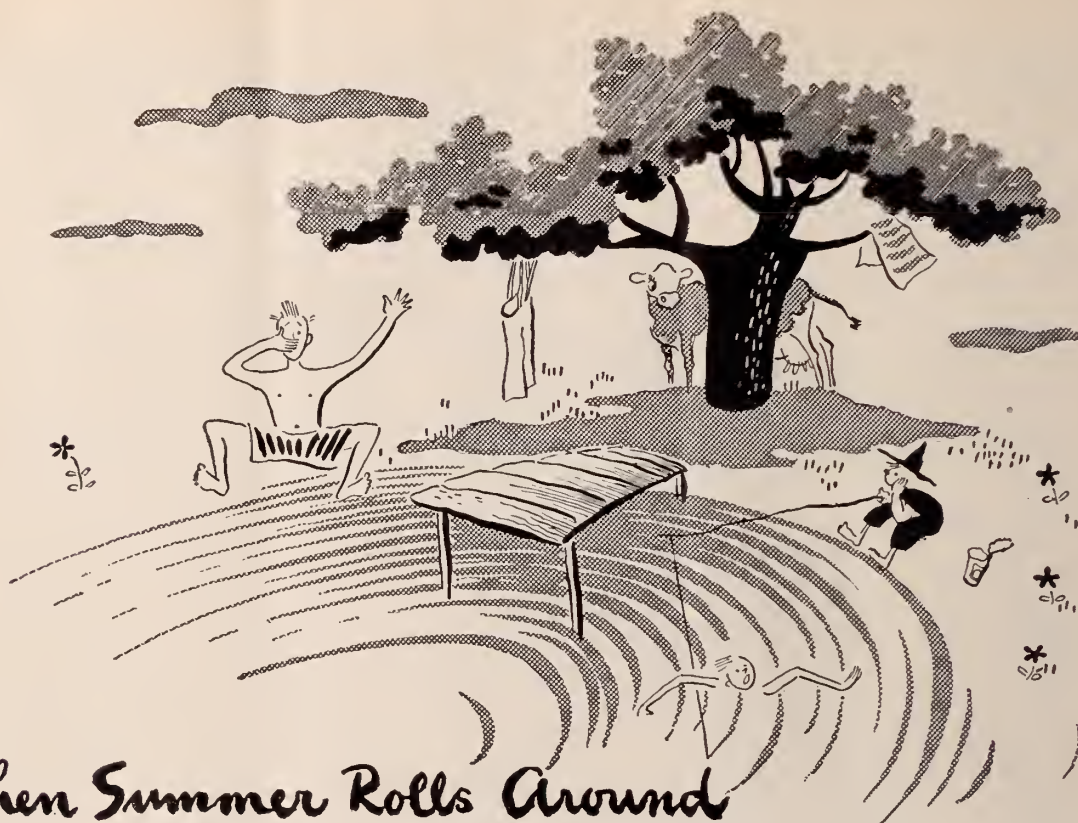
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VOLUME 63  
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AUGUST, 1945

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(Continued on Page 5)

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## BOOK REVIEWS

### BOOKS RECEIVED

**Public Medical Care: Principles and Problems.** By Franz Goldmann, M.D. Cloth. Price, \$2.75. Pp. 226. New York: Columbia University Press, 1945.

**Psychiatry in Modern Warfare.** By Edward A. Strecker, A.M., M.D., Litt.D., LL.D., Professor of Psychiatry and Chairman of the Department, School of Medicine, University of Pennsylvania; Consultant for the Secretary of War to the Surgeon-General of the Army and Army Air Forces; Consultant to the Surgeon-General of the Navy; Consultant to the Surgeon-General, U.S.P.H.S., and Kenneth E. Appel, Ph.D., M.D., Sc.D., Assistant Professor of Psychiatry and Chief of Clinic, School of Medicine, University of Pennsylvania; Lecturer in Psychiatry, School of Neuropsychiatry, U. S. Naval Hospital, Philadelphia; Medical Examiner for the Armed Forces Induction Station, Philadelphia, and Sometime Visiting Psychiatrist, Auspices Rockefeller Foundation, Eighth Service Command, U.S.A. Cloth. Price, \$1.50. Pp. 88. New York: The Macmillan Company, 1945.

### TWENTY-FIVE YEARS AGO

(Continued from Text Page 106)

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "What Are You Doing to Defeat Anti-Health and Anti-Medical Legislation"? by Walter C. Alvarez, M.D., San Francisco.—From present indications there are going to be four measures on the ballot in November which will strike directly at the public health.

(Continued on Page 10)

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MAYFAIR 321

## TWENTY-FIVE YEARS AGO

(Continued from Page 7)

One aims to stop all animal experimentation in California; another to abolish compulsory vaccination; another to establish a special licensing board for chiropractors, and the other is a referendum on a law which excludes osteopaths from those who are entitled to have and use hypodermic syringes. All of these measures are bad and should be defeated. They will be defeated only if the physicians who know the facts will educate the public in the next three months. . . .

From an Article on "Delayed Ulnar Palsy Following Elbow Injury," by Walter F. Schaller, M.D., San Francisco.—Recently there has come under our observation a number of cases of unilateral ulnar nerve palsy, due

to elbow injuries antedating the oncoming of paralysis by an appreciable interval of time. These cases, at first obscure as to etiology, we have now come to recognize as the delayed type of ulnar palsy following bone injuries involving the region of the internal condyle and causing subsequent pathology in the ulnar nerve in this locality. . .

## SOCIETY PROCEEDINGS

Excerpt from County Society, Los Angeles County:

The Los Angeles County Medical Association will not have any regular meetings during the months of June, July, August and September. . . .

League for the Conservation of Public Health.—In the Bulletin of June 17 the objects of this League are concisely and convincingly stated. In the issue of July 1st Dr. Walter V. Brem in an article entitled "Why Join the League?" ably and forcibly speaks of the purpose as

(Continued on Page 16)





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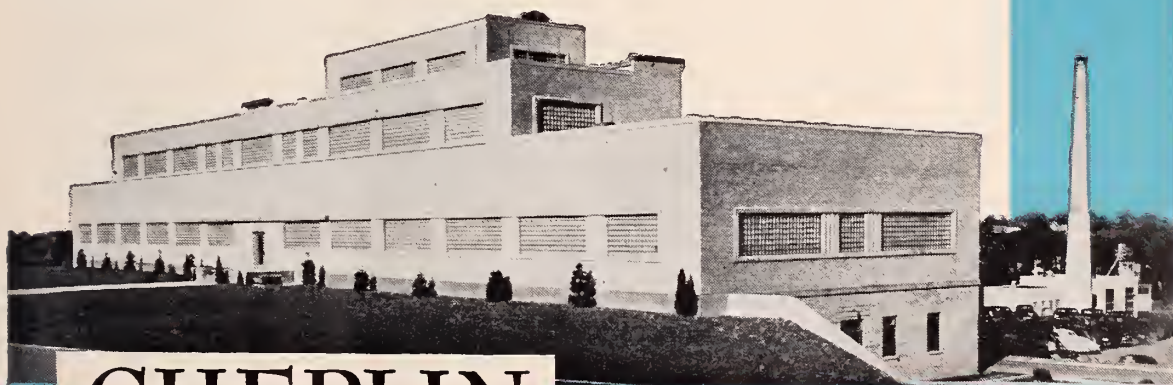


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### TWENTY-FIVE YEARS AGO

(Continued from Page 10)

defensive, offensive and constructive. He urges every one to join as a matter of civic duty. Be sure to consult your Bulletins and prepare for coming events.

Dr. Lyle H. McNeile, Chairman of the Committee on Public Health and Legislature, makes a strong plea in the Bulletin under heading, "Is the Medical Profession Asleep at the Switch?"

*Excerpt from Medicine Before the Bench: Obligations of Physician, Malpractice, Action for Damages.*—A case that all doctors might study with profit is that of John W. Hesler, respondent, v. California Hospital Company, et al, appellants. The complaint alleged that both de-

fendants were engaged in the practice of medicine; that the Hospital Company agreed to provide for the plaintiff all the necessary medical and surgical treatment and all necessary medical and hospital service during a certain period; that the doctor assigned by the hospital to the plaintiff's case failed to use ordinary diligence, care and skill in treating the plaintiff, and that by reason of such failure plaintiff's illness progressed unfavorably and he was put to great expense and damage in the sum of \$5,644. . . .

*Excerpt from Collected Clippings in Press: The Fountain-Head of Chiropractic; What of its Products?*—The Palmer School of Chiropractic advertises itself as "the fountain-head" of chiropractic. The following will give some intimation in regard to the character of the "stream" that comes from it: . . .

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## BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 106)

Attorneys S. S. Hahn and Harry C. Cogen, the doctor obtained a temporary writ compelling the State Board to appear in court June 11 for a hearing on the matter." (Los Angeles Herald and Express, May 31, 1945.)

"Dr. Clyde A. Pierson of San Bernardino today remains legally convicted of abortion but the California Fourth District Court of Appeals has cut in half the time he must serve in jail. The osteopathic physician was found guilty on three counts more than a year ago. Superior Judge Charles L. Allison pronounced judgment in this way. Dr. Pierson would have to serve one term of from two to five years. After that he would have to serve a second term for the second and third counts combined. The appellate court found yesterday that conviction on two of the counts was not according to law.

Therefore the abortionist has one conviction standing against him and must serve one term. Attorneys for the osteopath say the remaining single conviction will be carried to the Supreme Court. They are Jerome L. Richardson and Miguel Estudillo of Riverside. The appellate court, in reversing the lower court, agreed with one of Pierson's arguments. He said that the complaining witnesses were accomplices and their testimony required strengthening by other witnesses. (Redlands Facts, May 25, 1945.)

"Represented by the same attorney at whom he took three shots during an altercation in 1941, Dr. Carl G. Williams, 48, of 580 Moreno Avenue, Brentwood, pleaded not guilty to drunk driving and drunk charges in justice court today. Doctor Williams was arrested at 3:30 this

(Continued on Page 20)



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—Annals of Internal Medicine
- ★ **THE TREATMENT OF BACTERIAL ENDOCARDITIS WITH PENICILLIN**  
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— EDITORIAL J.A.M.A., 120:  
536 (OCT. 17) 1942

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### BOARD OF MEDICAL EXAMINERS

(Continued from Page 17)

morning when police discovered him seated behind the wheel of his automobile which had its bumper entangled with that of a parked car. The doctor was arrested in 1941 on assault with a deadly weapon after he emptied an automatic pistol at his maid, fired three shots at Attorney Robert Ryan and then held six policemen at bay at his own home. He was given a suspended jail term and placed on three years probation. Yesterday Ryan asked for a jury trial for his client which was set for July 10." (Los Angeles Examiner, June 12, 1945; Press dispatch from Santa Monica, June 11.)

"A Lennox chiropractor, Ramon S. Davis, 46, today is being held by Los Angeles county deputy sheriffs for allegedly performing an illegal operation on a 22-year-old Inglewood housewife, mother of two children, who is in general hospital seriously ill as a result of the operation,

sheriff's deputies said today. Dr. Davis, deputies continued, was arrested at his home at 3421 West 111th Street, early this morning by deputy sheriffs and Detective Joe Long of Inglewood police. Officers said that the chiropractor admitted performing the illegal operation and made a full confession to them. He will be arraigned, officers said, next Monday on charges of abortion." (Inglewood News, May 25, 1945.)

Nicolò Paganini (1782-1840).—The genius of Paganini was ever a delight to composer, performer and listener alike. Harsh parental treatment in childhood planted the seeds for his life-long precarious health which finally ended in tuberculosis of the lungs and larynx. At 52, he was a doomed man. One May evening, aroused as out of a lethargy, he took his violin and played before a portrait of Byron, whom he much admired. Suddenly, the violin and bow fell from his hands, he fainted, and the next morning was dead.—Warner's *Calendar of Medical History*.





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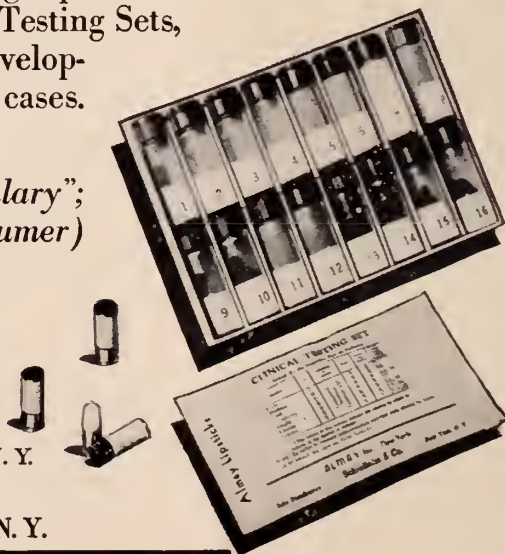
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\**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154  
*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

*Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241  
*N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592.

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In a recent address Major General Norman T. Kirk, Surgeon General of the Army, said in part:

The war in which we are engaged has produced many seemingly unsurmountable problems, problems without precedent in the development of new weapons, new methods of training, and new tactics. But none of these problems has been more difficult than the problems faced by our Medical Department in caring for the largest American Army in history, fighting in virtually all parts of the world. And yet, despite these problems, no Army at any time in history has achieved a record of recovery from wounds and freedom from disease comparable to that of the American Army in this war.

The Medical Department, its doctors, its nurses, its corpsmen, has saved the lives of 97 out of every 100 men wounded in battle who reach a hospital, compared with

92 in World War I. Seventy out of every 100 wounded overseas were returned to duty, and 27 were evacuated to this country.

During the past three years, the Medical Department has maintained a record of less than one death from disease per 1,000 men per year. During World War I, 19 out of every 1,000 men died each year from disease. During the Spanish-American War we lost 26 out of every 1,000 per year, and in the Civil War, 65 out of every 1,000 men died each year from disease.

In all, during this war, 12,000 men died from disease from December 7, 1941, to May 1, 1945. In World War I, 62,670 men died from disease; in the Spanish-American War, 3,500 died from disease, and in the Civil War, 336,216 men of the Union and Confederate armies died from disease.

(Continued on Back Advertising Section, Page 30)





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Roster of Editorial Board appears in this issue at beginning of  
California Medical Association department. (For page number  
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**Leaflet Regarding Rules of Publication.**—CALIFORNIA AND  
WESTERN MEDICINE has prepared a leaflet explaining its rules  
regarding publication. This leaflet gives suggestions on the  
preparation of manuscripts and of illustrations. It is suggested  
that contributors to this Journal write to its offices requesting a  
copy of this leaflet.

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## EDITORIALS

### PRESENT STATUS OF PROPOSED SICKNESS INSURANCE LAWS FOR CALIFORNIA —TWO INTERIM COMMITTEES

**California Senate and Assembly Appoint Interim Committees to Study Sickness Insurance.**  
—When the 56th California Legislature ad-  
jourled on June 16, last, two major compulsory  
sickness insurance bills (Governor Warren's A.B.  
800 and C.I.O.'s A.B. 449) were not placed on  
the Governor's desk, because each failed of pas-  
sage in the Assembly where they originated,  
thereby preventing subsequent consideration by  
the State Senate and the Governor.

However, even though the much discussed  
measures failed to secure legislative approval,  
two other resolutions closely related to sickness  
insurance,—one by the State Senate and the  
other by the State Assembly,—secured favorable  
consideration by their respective bodies. The  
resolutions authorized two Interim Committees,  
one composed of seven Assemblymen with an  
appropriation of \$50,000.00, and the other of  
five Senators, with allocation of \$20,000.00, the  
allocations being intended to cover investigation  
costs of voluntary and compulsory sickness in-  
surance systems in our own and other States.  
Scope of the measures providing for the interim  
committees may be gleaned by reading the text  
of the two resolutions. (In the July issue of CALI-  
FORNIA AND WESTERN MEDICINE, the Senate  
Resolution appears on page 22 (Item VII), the  
Assembly Resolution on page 29 (Item XII).

Members of the California Medical Associa-  
tion may well pause to consider in advance the  
possible significance of interim committee in-  
vestigations as outlined in the two resolutions, and  
the results of the reports that may be submitted.  
If either the Assembly or Senate Committee, or  
both, submit to the next Legislature a bill or bills  
in advocacy of a compulsory sickness insurance  
system for California, it will mean a legislative  
battle even more tense than that which took place  
during the first six months of the present year.  
This patent fact should be understood by all  
physicians.

\* \* \*

**Physicians Must Continue Their Campaign  
of Education.**—Many phases of this year's  
legislative struggle over sickness insurance plans  
have been given space in the OFFICIAL JOURNAL,  
and all signs indicate that much more comment  
must be made thereon.

It is to be hoped that component county socie-

ties and all members of the California Medical Association will appreciate the importance of the issues at stake in relation to medical practice in the future.

Every physician should keep abreast of the subject, and when opportunity permits, communicate his views to friends and patients. In that way, support will be given when citizens go to the voting booths to cast their ballots for legislators or initiative measures.

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**CONSTRUCTIVE PROGRAM FOR MEDICAL CARE—RECENT PLATFORM ADOPTED BY A.M.A. TRUSTEES AND A.M.A. COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS**

**An Important Announcement.**—In Chicago, on June 22, 1945, at the close of a joint meeting, the Trustees of the American Medical Association and the A.M.A. Council on Medical Service and Public Relations publicized an important statement on 14 principles involved in medical care. A full page presentation of the platform, presented in this issue of CALIFORNIA AND WESTERN MEDICINE on page 62, should be read.

In connection with that pronouncement, it is heartening to read the minutes of the A.M.A. Council on Medical Service and Public Relations as given in the *J.A.M.A.*, issue of July 21, 1945, on page 889, and to note not only the wide range of important topics then considered, but especially the aggressive spirit manifested by the Council, and the actions taken. If the proposals that were approved are properly implemented, it will mean that our national organization,—American Medical Association—will be brought into a much-to-be-desired closer and more sympathetic contact with its constituent state associations and their component county societies.

The funds of our national organization can be spent to no better advantage, than when wisely expended to promote a broad educational campaign among its state units,—through a program that will make for a clearer understanding by physicians throughout the Union, concerning best ways and means of providing adequate medical care for all citizens, with special reference to voluntary sickness insurance plans, and other measures that are in harmony therewith.

Since the American Medical Association, speaking for the physicians of the United States, has now announced 14 principles to be observed in a "constructive program for the extension of improved health and medical care for its people," it is incumbent upon the governing bodies of each constituent state association to give the same careful consideration, and to notify the A.M.A. authorities, if they are not in agreement therewith. Otherwise the principles will stand as the expression of opinion held by the profession.\*

\* \* \*

**Component County Societies Should Study the 14 Principles.**—Each of our County Societies, in order to bring the subject before its

members might appoint, say, a committee of three, to prepare a paper with brief comment on each of the 14 principles, the subject to be then thrown open for further general discussion and elucidation. In this way, physicians in their own minds, would clarify the various factors, and thus be better prepared to discuss the subject with individual lay friends or groups. Through such procedure it should be possible to bring an increasing number of voters into harmonious affiliation with the medical profession, particularly when adverse legislation is proposed. By now, it must be evident to all who observe trends, that the proponents of theoretical compulsory sickness plans are more than active in the promotion of their compulsory sickness plans and obsessions, not only in one or two but nearly all the States of the Union, as well as in the Federal Congress in Washington. The medical profession must meet its responsibilities and orient citizens concerning the issues involved.

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**E.M.I.C.—AS PER FEDERAL CHILDREN'S BUREAU OUTLOOK**

**E.M.I.C. Since March 29, 1943.**—CALIFORNIA AND WESTERN MEDICINE in its issue of June, 1943 (p. 315) began a series of comments and articles on E.M.I.C. (Emergency Maternity and Infant Care) with which program nearly all obstetricians and physicians in general practice, by now, should have had considerable experience. Much of the comment was of an adverse or critical nature—not because of the basic objective of giving to wives and infants of enlisted men all possible and best maternity and pediatric care—but because of the empiric, and in a certain sense, high-handed rules and regulations put forth by the Federal Children's Bureau of the United States Department of Labor.

Information Circular No. 13 of March 29, 1943, listed the conditions under which State Health Departments would be given Federal monies to aid in carrying on the professional services required. The first congressional appropriation or subsidy or grant to carry on the E.M.I.C. work in the different States was for \$1,200,000. That the Federal Children's Bureau officials (Miss Katharine Lenroot, chief; Dr. Martha M. Eliot, associate chief; and others) failed somewhat to sense the bigness of the problem then confronting them is shown by the Federal deficiency and other appropriations subsequently granted; the expense of the work (exclusive of many heavy administrative costs covered by State Boards of Health from State funds) now approximating some \$70,000,000.

The initial proposal by the Children's Bureau officials was that \$35.00 per patient would be ample compensation to a physician for the extensive pre-natal, confinement, and post-natal care to mother and child! The California Medical Association committee insisted that the fee must be at least \$50.00 per case and because of its firmness on this point, that is practically the fee today throughout the United States.

\* Too late for comment: C.M.A. Principles (see p. 61).



**Articles on E.M.I.C. in Lay Press.**—Since March, 1943, physicians who have been interested in the E.M.I.C. program and procedures have had opportunity to read many articles and comments thereon, in both medical and lay press.

A display article in *Collier's* of August 4, 1945 (p. 18) with caption "Babies for Free," written by a lay contributor is the reason for the present remarks. Throughout that article, praise, outspoken or implied, is given in generous quantity to the Federal Children's Bureau and its administrative chiefs. Perusal of the article by lay persons not informed concerning the real facts could easily leave the impression that the big donation in the E.M.I.C. program was by the Federal Government, acting through the Federal Children's Bureau.

As a matter of fact, the major donation has been made by the thousands of physicians who, in loyalty to our Country, and working in conjunction with State Boards of Health and Local Health Officials, have made the service possible.

Some of the battles over bureaucratic directives between State Medical Society committees and the Federal Children's Bureau have been referred to in past issues of *CALIFORNIA AND WESTERN MEDICINE* and other medical journals, and no special reference need be made thereto at this time.

\* \* \*

**Appreciation Would Be In Order.**—It would have been a gracious expression of understanding and appreciation by the officials of the Federal Children's Bureau,—when they were interviewed for the article in *Collier's*,—had they impressed upon the author that some words of praise would be in order for the thousands of medical men and women who have made the E.M.I.C. program a success.

The bigness of the donation by physicians is evidenced by the estimate that some 1,500,000 mothers and babies will have received care through E.M.I.C.

The article in question bears out the comment made by more than one medical commentator, that papers and other promulgations emanating during recent years from the offices of the chiefs of the Federal Children's Bureau indicate a distinct leaning to the left, with long-range thought on their programs to promote legislation of the Wagner-Murray-Dingell type.

Of course, it is the privilege of such officials to so think and hold, if such be their beliefs or desires. However, it is well for members of the medical profession to understand the situation.

\* \* \*

**Some Excerpts.**—For convenience of readers, a few brief excerpts from the *Collier's* article referred to above, follow:

Katharine F. Lenroot, head of the Children's Bureau, expressed the spirit of the thing this way: "There is one casualty which no responsible nation should ask a fighting man to face. That casualty is the preventable injury of his wife or child back home."

The program is under the direction of Doctor Martha

M. Eliot, associate chief of the Children's Bureau but state health departments, and not the federal government, administer it locally. The States receive E.M.I.C. funds from the Children's Bureau and pay them out in check to doctors, hospitals and nurses. The cost so far has been almost \$70,000,000. The only federal string attached is that participating hospitals and doctors must meet minimum requirements set by the Children's Bureau.

\* \* \*

Many doctors who cheerfully accept E.M.I.C. because there's a war on, would kick mightily if anybody attempted to extend it after the war. They say that the fee—\$50 for a general practitioner—is too low. And they object to being checked up on by E.M.I.C. administrators as to the number of visits and kind of care.

Such objections do not come up, however, at group practice clinics, where doctors either work on salary or receive their share of income, and where the clinic itself sees to it that standards are maintained.

\* \* \*

As an E.M.I.C. administrator says, "A doctor may vote one way at his medical society meeting, and then, when he is confronted with an individual woman who needs his help, act quite another way, forgetting all about politics and doing all he can to help her."

\* \* \*

Although the E.M.I.C. program is a purely wartime measure, due to end six months after peace, its findings will be important to the nation and to Congress in developing postwar health plans. Partly because of E.M.I.C. experience, many new provisions for maternity and child care are included in the national health insurance section of the revised Wagner Social Security bill, now before Congress.

## A "DOCTOR'S GUILD" ORGANIZED IN SAN FRANCISCO

**Members of Southern Pacific Hospital Staff Organize.**—A new medical organization that may be an advance expression of similar movements throughout the United States was given recent newspaper publicity. From the *San Francisco News* of August 3, the following excerpt:

### DOCTORS BAND INTO GUILD

Organizations of a guild of 40 doctors and dentists on the staff of Southern Pacific Hospital to act in the mutual interests of the profession was announced here yesterday.

A Spokesman of the organization declared emphatically the group is not a union, but admitted one of its concerns would be maintenance of good working conditions, which might eventually include wages and hours.

The group will not be affiliated with any labor organization, but will act solely for professional men connected with the S. P. Hospital.

The guild is believed to be the first such organization of doctors and dentists in the United States. . . .

Delegates who were present at the Special Session of the California Medical Association held in Los Angeles on January 4-6, 1945, may recall Resolution No. 11 introduced by Dr. Daniel W. Sooy of San Francisco, in which possible formation of a "guild" was mentioned. Resolution No. 11 (not adopted) as it appears in the minutes of the C.M.A. House of Delegates, follows:

### RESOLUTION No. 11

*Be it Resolved*, That a guild of the licensed physicians and surgeons of the State of California be formed to

function as a guild under by-laws similar to or acceptable to organized labor with the express desire that a guild thus formed have its fee schedule accepted by organized labor so that should legislation now pending infringe upon the rights of the medical men as governed by the above-described fee schedules, then this guild could affiliate with the two branches of organized labor to further the practice of medicine in the State of California.

Concerning comment on the above, it is possible that the publicity given to the Association of American Physicians and Surgeons of Gary, Indiana, may have had somewhat to do with the organization of the San Francisco Guild. (For reference to A.A.P.S., see CALIFORNIA AND WESTERN MEDICINE, for April, page 234.)

That such a movement should have taken definite form is an indication of the trend of thought by many well-known members of the medical profession. (For press items in this issue, see p. 102.)

### "BULLETIN" OF THE ALAMEDA COUNTY MEDICAL ASSOCIATION

Vol. I, No. 1 of *The Bulletin of the Alameda County Medical Association*, is a 6 x 9 publication of 40 pages. In format and contents this first issue of August, 1945, is a distinct credit to Editor Milton H. Schutes, M.D., Executive Secretary Rollen W. Waterson and their associates.

From the opening editorial the following excerpts will reveal somewhat of the story of this welcome addition to the group of the other excellent bulletins of C.M.A.'s component county societies. The OFFICIAL JOURNAL of the California Medical Association extends all good wishes.

Excerpts follow:

"GOOD MORNING DOCTOR!

"Meet the new member—THE BULLETIN of the Alameda County Medical Association!

"Examine it critically. It is Volume I, Number 1, and is already sitting quite pretty, thanks to its business management. It is its own prediction of a never ending line of volumes. Don't be in a hurry to ease it into your wastebasket. It may some day become a valued collectors' item!

"THE BULLETIN will come to you once a month, along with your office bills, loaded from front to back cover with information of interest; most of it factual, some of it debatable, a little of it humorous and gossipy, with possibly a bit of detritus now and then.

"Its overall purpose is to keep you informed of what your association is doing and of what your officers and committeemen are thinking and planning. More specifically, each issue will include the minutes of the association and its council and committees, the president's message, notices from the recording secretary and the executive secretary, a calendar of meetings of the association and of hospital staffs, editorials by members of the editorial board, a column for you in which to cheer or gripe or otherwise expose yourself, a column for the Bureau of Medical Economics, one for hospital news, one for the Woman's Auxiliary, and another for vital statistics from the city and county health departments, and only very occasionally, we hope, one for obituaries. . . .

"THE BULLETIN will serve not only as a bill-board for the association, but also for a carefully selected group of commercial firms in trimutual benefit. Their advertisements will be conveniently placed for your easy informative inspection

"Your general approval is anticipated, Doctor. But, whether it be a little boutonniere or a big bronx-cheer, this new member, like the meandering brook, will go on—and it could be, forever."

### WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

Letter from C.M.A. President Philip K. Gilman

To the Members of the  
California Medical Association:

In the past year, particularly the first half of 1945, it has been the pleasure of the officers of the C.M.A. to come into a more frequent and closer contact with the Woman's Auxiliary to the California Medical Association than we have enjoyed in recent war years. During the course of this contact I have had a good chance to evaluate the work of the Auxiliary and to assess the function which this organization has played and can play in furthering the ends of scientific medicine.

In my opinion, the Woman's Auxiliary is one of the finest instruments the medical profession has for the advancement of our aims. Unfortunately, the Auxiliary has not always been extended the leadership necessary to achieve its full potential; unfortunately, in some areas the Auxiliary is looked upon as an extraneous growth or is merely tolerated by the busy doctors in the medical society. In one or two spots there has even been some antagonism toward the formation of county auxiliary units.

The busy women who make up the Woman's Auxiliary are working for the good of their husbands. They are willing to devote endless time and boundless energy in carrying out the aims and ideals of their husbands' medical organizations. In short, they represent a tremendous resource which I fear we may have overlooked in past times.

Let us now acknowledge the good work the Woman's Auxiliary has done in the past. And let us now determine that this good work will be carried on and expanded in the future. Let us encourage our good wives in their efforts to help us in our profession. If the Auxiliary unit in your county is not functioning actively, lend some aid; supply some leadership. If there is no unit in your county, or if the unit is temporarily dormant, get behind it.

Let your wives in on your organization problems; you may be surprised at how much help they can give you. Ask them to your meetings, particularly when problems of medical economics are to be discussed. See that they are enabled to meet regularly, to hear qualified speakers and to take an active part in the social and economic side of medical practice. Their energies and accomplishments will repay you manifold for the little effort it will take on your part to extend a helping hand.

The California Medical Association has recently gone through a period of great economic and political stress. The temporary lull right now will again be replaced by even greater demands on our members if scientific, ethical private medical practice is to survive. In the task ahead of us there is a vital job that the Woman's Auxiliary can do. And it will do this job, or any other we ask, if we will only point the way and supply the encouragement.

Let's get behind the Woman's Auxiliary to the fullest and harness the great power residing in its members. Released, this power will do tremendous good for the medical profession.

PHILIP K. GILMAN, M.D., *President.*

I don't know who my grandfather was; I am much more concerned to know what his grandson will be.  
—Abraham Lincoln. (Gross, *Lincoln's Own Stories*, p. 12.)



## EDITORIAL COMMENT†

## POLIOMYELITIS FROM FLY-CONTAMINATED FOOD

Evidence has accumulated within recent years that the alimentary tract may be one of the most important portals of entry for poliomyelitis virus. The virus has been repeatedly demonstrated in human stools, in sewage and in flies collected in epidemic areas. Fly-contaminated food may thus be a theoretically logical source of human infection with polio virus. Experimental evidence in support of this hypothesis is reported by Ward<sup>1</sup> and his associates of the Section of Preventive Medicine, Yale University School of Medicine.

The evidence was drawn mainly from the 1944 poliomyelitis epidemic in Catawba County, North Carolina. This outbreak was rural in character. Most of the affected families were of the lower income group, hygienic conditions poor, and outdoor privies the rule. The weather was hot and flies abundant. Foods were exposed in 20 homes of poliomyelitis patients within a week of the onset of the disease. The food was purchased locally and consisted of bananas. These were peeled and sliced on the spot, and sprinkled with a little sugar and water. About half of the food samples were supplanted by fly-bait, consisting of liver or fish, likewise obtained locally. One or two plates of this food were exposed for 24 to 48 hours in or about each home. These were usually placed in the kitchen, on the back porch or under a fly-trap in the yard. At the end of the exposure the food was frozen on dry ice, transported to the laboratory and held in a frozen state until used for feeding experiments. In most instances flies were observed to rise from the food at the time of collection. There was gross evidence of fly-contamination in the form of vomit or fecal spots. Of the flies trapped at the time of exposure, 80 per cent have been identified as *Musca domestica*.

Chimpanzees were selected as the test animals. Howe and Bodian<sup>2</sup> of Johns Hopkins University had previously shown that chimpanzees are extremely susceptible to orally administered poliomyelitis virus, producing both paralytic and non-paralytic infections in these animals. In non-paralytic cases large amounts of the virus are given off in the stools. The only recognizable symptom is fever of moderate intensity (101°F.). This viral enteritis is followed by specific antibody production.

Under strictest quarantine conditions two chimpanzees were each fed approximately one quart of fly-contaminated bananas daily for from 6 to 10 days. Rectal temperatures were taken daily, and daily stool specimens collected. The

stools prepared by ultracentrifugation<sup>3</sup> were tested for virus by intracerebral inoculation into rhesus monkeys.

The pre-feeding stool specimens of both animals gave negative tests for poliomyelitis virus. Three or four separate stool specimens from each animal taken during the post-feeding period gave positive tests for polio virus, producing typical fever, paralyses, and cord and medulla lesions in test monkeys. With each chimpanzee the virus persisted for several weeks after the last contaminated feeding. Both chimpanzees thus acquired a subclinical infection (or carrier state) with apparent multiplication of the virus in the intestinal tract.

From these data Ward concludes that fly-contamination of food in epidemic areas is presumably an important method of spread of poliomyelitis virus to human beings. He plans testing this conclusion by reduction of the number of flies in a selected locality during some future epidemic.

P. O. Box 51.

W. H. MANWARING,  
Stanford University.

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## IN VIVO INHIBITION IN ANTIBIOTICS

In 1943 Schatz<sup>1</sup> and his associates of the New Jersey Agricultural Experiment Station isolated streptomycin from broth cultures of *Actinomycetes griseus*. The new antibiotic was found to be active both in vitro and in vivo against a large number of both gram-positive and gram-negative microorganisms. Robinson<sup>2</sup> and his associates of the Merck Institute for Therapeutical Research afterwards found streptomycin to be relatively non-toxic for mice and rabbits and superior to streptothricin in its therapeutic efficiency against experimental gram-negative infections of these animals. They suggested its use in human medicine as a supplement to penicillin, which is inactive against typhoid fever, bacillary dysentery and other gram-negative diseases.

A preliminary report of the clinical application of streptomycin to the treatment of typhoid fever patients is currently made by Elias and Durso<sup>3</sup> of the Wyeth Institute of Applied Biochemistry, Philadelphia. A technique for the titration of streptomycin was first developed by these biochemists. This was based on the method proposed by Foster<sup>4</sup> for the titration of streptothricin, *B. subtilis* being used as the test organism. They found that an old laboratory culture of *E. typhosa* was sterilized by the addition of 2 Foster units of streptomycin per cc. of serum-broth. Recently isolated typhoid cultures were found to be slightly more resistant. All, however, were killed by 6 units of streptomycin per cc. of serum-broth.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

Daily doses of streptomycin ranging from 1 million to 4 million units given as divided doses at 3 hour intervals were then administered intramuscularly or intravenously without apparent toxic reactions to several typhoid patients. Urinary excretion was demonstrable within 90 minutes after the first fractional dose and was completed within 72 hours after the final dose, from 44 to 70 per cent of the total administered dose being recovered from the urines of different patients. A peak serum level (28 units per cc.) was reached within a few hours after the first dose. The serum titer fell to zero within 24 hours after the last dose. Four million daily units given by the intravenous route gave rise to a concentration of from 100 to 130 units per gram of fresh feces.

Given by mouth, four million daily units produced no demonstrable blood level, and only 1 per cent total recovery from the urine. At least 64 per cent of the oral dose was eliminated in the stools, the stool titers often reaching as high as 20,000 units per gram of feces. Positive stool cultures of *E. typhosa* were isolated from patients after prolonged oral therapy with as much as 15 million units of streptomycin. The organisms thus isolated showed no acquired resistance to streptomycin, all being killed by 6 units of streptomycin per cc. of serum-broth.

Bearing in mind the enormous dosage administered in these patients, and the lack of acquired streptomycin resistance, Elias concludes that some effective inhibitory substance for streptomycin exists in the intestinal contents. If so, streptomycin would be without theoretical promise as an intestinal antiseptic against gram-negative infections. Its only theoretically predictable therapeutic value would be against the bacteremia which usually accompanies typhoid infections. Detailed report of its clinical value against this phase of typhoid fever is promised for the near future.<sup>5</sup> Meanwhile the reported data may serve a useful purpose in emphasizing the existence of strong inhibitory factors in the human body, which have often been overlooked in the exploitation of such commercial products as bacteriophage and leucocytic extract.<sup>6</sup>

A second recent example of such inhibitory factors is currently reported by Klein and Stevens<sup>7</sup> of the Department of Bacteriology, University of Pennsylvania. These investigators compared the in vitro and in vivo effects of 20 detergents and related compounds against influenza A virus. Seven of these were found to be virucidal in vitro when tested in dilutions often as high as 1:16000, sterilization being completed within from 60 seconds to ten minutes. However, none of these compounds when administered intranasally as a 5 to 10 per cent solution either by instillation or by prolonged spray (18 to 120 minutes) protected mice against experimental infection with influenza A virus.

The results clearly show that in spite of the high in vitro activity of many of these compounds they are completely inert in vivo even under optimal conditions of prophylaxis. The utiliza-

tion of such compounds as gargles or sprays for human prophylaxis against influenzal infections would be of questionable value.

P. O. Box 51.

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#### Strümpel-Marie Disease

Adolph Strümpel (1853-1925), in the second volume of the first edition of his *Lehrbuch* (Leipzig, 1884, page 152), described this peculiar form of chronic arthritis. A portion of the translation follows.

"Those forms may here be mentioned in passing as a remarkable and, as it seems to us, a distinct disease in which there results a gradual and painless complete ankylosis of the vertebral column and hip joints so that the head, the trunk and the thighs are firmly united to each other and become completely stiff, while all the other joints retain their normal mobility. It is apparent that a characteristic modification of the posture and gait must occur as a result. We have seen two quite similar cases of this peculiar disease."

He discusses the entity in more detail in an article, "Bemerkung über die chronische ankylosierende Entzündung der Wirbelsäule und der Hüftgelenke. [A note on Chronic Ankylosing Inflammation of the Vertebral Column and Hip Joints]." It was published in the *Deutsche Zeitschrift für Nervenheilkunde* (11:338-342, 1897) as a comment on the preceding article on the same subject by Bechterew.

Pierre Marie (b. 1853) wrote "Sur la spondylose rhizomélifique [Rhizomelic Spondylosis]" in the *Revue de Médecine* (18:285-315, 1898). A portion of the translation follows:

"In the session of February 11 of this year, I presented to the Société médicale des Hopitaux two patients afflicted with a disease whose symptoms, identical in both cases, seemed to me to be sufficiently interesting to be brought to the attention of clinicians. In this preliminary discussion, I indicated the principal characters of this disease entity and particularly stressed the extremely marked rigidity of the spine and the more or less complete ankylosis of the coxofemoral and scapulohumeral joints. Calling attention to the fact that the articulations of the roots of the extremities were affected with this kind of spinal rigidity, I proposed to designate it by the name *rhizomelic spondylosis*."

After a careful review of the facts observed in his cases, he concludes:

"It seems to me that it is permissible for clinicians to contrast deforming polyarthritis affecting the small joints of the extremities (acromelic deforming polyarthritis) with the ankylosing process that attacks primarily the spine and the joints at the roots or attachments of the extremities (rhizomelic spondylosis)."—R. W. B., in *New England Journal of Medicine*.



## PRINCIPLES ON HEALTH INSURANCE CALIFORNIA MEDICAL ASSOCIATION

These principles were adopted by the California Medical Association Council on August 12, 1945

It is in the public interest that the California Medical Association, representing the doctors of medicine practicing their profession in the State of California, publicly make known the principles which should form the basis of any health insurance program, and from which there should be no material deviation if the public welfare is to be properly and adequately protected. The public health and good medical practice are inextricably interwoven and interdependent.

This statement is made with the understanding that the public is entitled to the best possible quality of medical service and access thereto. The medical profession must be in a position to render such service if the best interests of the public are to be served.

The manifold and constant advances in the science and practice of medicine are put to public benefit only when they can be utilized by an alert and progressive medical profession. The public is entitled to profit by all scientific advances and the public welfare demands that the medical profession have complete scientific freedom in their application.

### Principles

Any sound health insurance program should fulfill each of the following basic points:

1. It is of primary importance that the people should be enabled to provide for the costs of illness on a regular budget basis during periods of good health and stable earning power, so that they may have a medical-economic security. It is vital, however, that the distribution of costs should be undertaken in a manner which will still guarantee the finest possible medical care and which will prevent any deterioration in the quality of medical service.
2. To serve the ultimate public interest any health insurance plan must:
  - a. Be voluntary and not compulsory in nature,
  - b. Retain individual initiative in medical practice, so that the incentive for further advance in scientific medicine may continue,
  - c. Fully protect the freedom of choice, both of the patient in choosing a physician and of the physician in choosing his community, type of practice and professional procedures,
  - d. Offer medical care in coöperation with allied services against serious illness or injury,
  - e. Offer participation at a cost within the means of all employed persons and income-receiving families, and
  - f. Provide a fair reward to those rendering the service which will give continued stimulus to scientific medical development and sound medical practice.
3. The function of state government should be to encourage voluntary health insurance programs but not regiment the patient and the medical profession or operate compulsory health insurance plans established by political means; to further this function, the state should coöperate with medical and allied professional groups to provide the availability of medical and associated care through acceptable prepayment plans in areas where a shortage of medical and hospital facilities exists.
4. It is in the public interest that the human factor in medical care be thoroughly recognized; the sanctity of the patient-physician relationship must be maintained and the method of providing medical care must not become enmeshed in bureaucratic red tape and a system of tickets, coupons, questionnaires and other political controls and delays.
5. It is essential for the public welfare that there exist in each state a complete inventory of all medical resources and facilities. It is in the public interest that a coherent and comprehensive educational program be undertaken, preferably by responsible authorities and the medical profession in a coördinated effort, to advise all the people of the state on the facilities and services available to them in the event of need and to encourage sound public health measures for the prevention of both accidental and non-accidental illnesses and injuries.
6. There should be a coördinated program on the part of all groups concerned with this problem, directed to the extension of voluntary health insurance plans, so that our people may systematically provide for their health care on a budget basis.

# CONSTRUCTIVE PROGRAM FOR MEDICAL CARE

## AMERICAN MEDICAL ASSOCIATION

This platform was adopted by the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association on June 22, 1945.

### Preamble

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled.

### Program

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all the people:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives:

2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

3. Increased hospitalization insurance on a voluntary basis.

4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.

7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

13. Adoption of federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular army, navy and United States Public Health Service.



## ORIGINAL ARTICLES

## Scientific and General

## SOME OBSERVATIONS ON DEFICIENCY DISEASE WITH SPECIAL REFERENCE TO THIAMIN\*

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AND

LOUIS D. GREENBERG, PH.D.

*San Francisco*

IT should be realized that nutritional deficiency disease which is clinically manifest represents an advanced deterioration in metabolism, one that has resulted in either profound impairment of function or frank structural damage to tissues. It is evident a significant metabolic inadequacy must precede such alterations. Also, it should be recalled that most deficiency diseases recognized clinically is "acute" deficiency resulting from a nearly complete absence of an essential nutrient. What is the influence on the organism of less severe deficiency operating over long periods of time? One may ask if there are such states. Studies of deficiency disease in animals leave little doubt of this. For example, inadequate thiamin or riboflavin will retard growth without outward manifestations of deficiency and vitamin C deficiency will impair skeletal and dental development without the more obvious manifestations of scurvy. Thiamin deficiency in the rhesus monkey is reflected by diminished food intake, apathy and weight loss long before the eventual collapse. Manifestations of either the early or chronic deficiency states are usually not distinctive enough to be recognized with any degree of certainty. It is desirable, then, to establish objective methods for nutritional assay to detect suboptimal nutritional states. This is of importance in determining the extent of malnutrition in population groups, in evaluation the possible rôle of deficiency in diseases of obscure etiology, as well as in management of the individual case.

With these facts in mind we, as others, have endeavored to develop such methods of examination. Recently we reported data on the detection of subclinical vitamin C deficiency.<sup>1</sup> The present report is concerned with a brief review of some current studies of thiamin deficiency and with the writers presentation of a point of view with regard to nutritional deficiency. We have recently described a sensitive and accurate method for determination of thiamin in the blood, and shown, in the rat, that the concentration in the blood parallels the tissue content and the thiamin intake.<sup>2</sup> The rat adapts himself remarkably well to highly purified diet. Such a diet supplemented with the known vitamins required by this animal and with graded doses of thiamin reveal interesting data. A thiamin supplement of 40 gamma daily produces an excellent growth curve, 10 gamma a relatively poor one, and 20 gamma an intermediate curve.

Currently, a study of thiamin deficiency in the monkey is being conducted in which unanticipated degenerative

changes have been found in the central nervous system\* giving clinical manifestations which are certainly not of a type that would lead one to think of thiamin deficiency. The blood thiamin in the adequately fed monkey ranges from 5 to 10 micrograms per 100 cc. In thiamin deficiency experiments, the animal's food intake and weight begin to fall off at about the same time the blood thiamin level falls below five micrograms per 100 cc. This occurs approximately two weeks after the thiamin supplement is withdrawn.

The metabolism of thiamin appears to be similar in the monkey and man. In a series of 33 normal individuals (coöperative medical students) blood thiamin concentrations have ranged from 4.8 to 12.8 micrograms per 100 cc. with only three cases below five and none below four micrograms. Observations of two students examined subsequently are of interest. One of these complained of lassitude and presented a characteristic cheilosis with crusted fissures at the angles of the mouth. The blood thiamin content was low (3.5 microgram per 100 cc.) even though the sample was not taken until ten days after moderate supplements of vitamin B complex, including thiamin, had been taken. The lesions cleared with further B complex supplements. In a second student, showing an initial blood thiamin of 4.3 microgram per 100 cc., urinary excretion studies were carried out. The fasting excretion of thiamin and the excretion following a test dose was low and remained so even after a five mg. supplement had been administered daily for six days. In this case we have rather definite evidence of depletion of tissue stores correlated with a lowered blood concentration. In collaboration with Dr. Logan Gray of San Mateo, blood thiamin determinations have been made in a series of cases in whom thiamin deficiency was suspected either on the basis of suggestive clinical manifestations or of a poor nutritional history. Many of the patients showed blood thiamin values ranging from two to four micrograms per 100 cc. These observations require extension and further analysis but it is perhaps noteworthy that a number of the patients suffered from complaints ordinarily not considered referable to thiamin deficiency. From the data at hand it would appear that estimation of blood thiamin will afford a reasonably accurate method for determining the adequacy of thiamin intake and the tissue stores available for effective metabolism.

## COMMENT

There are opposing points of view with regard to deficiency disease. On the one hand are those who would, with little foundation, ascribe most human ills to nutritional deficiency. Perhaps due to an inherent conservatism and as a reaction to the commercialization of vitamins, many physicians have assumed an ultra conservative and equally unwarranted position. It is not logical to deny the existence of vitamin C deficiency until the teeth fall out or a vitamin B deficiency unless the patient exhibits a florid pellagra or beriberi.

It should be recalled that nutrition as applied to medicine is just approaching a sound scientific foundation. Our dietary habit has evolved with little benefit or planning based on knowledge. As a nation we have accustomed ourselves to prefer bread from a highly refined wheat to which, only recently, under the exigencies of war, has been restored the thiamin and riboflavin removed in the process. In the early days of artificial infant feeding the occurrence of infantile scurvy became so frequent that a committee was appointed by the pediatricians to study the problem. It is doubtful if the knowledge is yet universal that some source of vitamin C is required to supplement the diet of the bottle fed infant. Scurvy is rarely manifest before nine months but who

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From the Divisions of Pathology and Pharmacology, University of California Medical School, San Francisco. Supported by the Christine Breon Fund for Medical Research and the A. B. Miller Fund.

† The distribution and character of these lesions is somewhat different than those in Wernickes syndrome. A detailed study of these lesions is being made and will be reported later.

could deny impairment of health and resistance before the obvious breakdown. The nutritional requirements of pregnancy deserve much more consideration and study. Recent reports indicate that health and well-being of the newborn infant can be correlated to a considerable degree with the adequacy of the maternal diet.<sup>3</sup> A fascinating and undoubtedly important field of study lies in the possible rôle of preclinical or chronic nutritional deficiency in the pathogenesis of illness of obscure etiology. We have reported studies which have strongly suggested a contributory influence of vitamin C deficiency in rheumatic fever and rheumatoid arthritis.<sup>4,5</sup> Man has inadvertently subjected himself in many cases to uncontrolled experimentation in chronic deficiency of one or several essential nutrients. To what extent do these deficiencies play a rôle in the chronic disease states from which he suffers? One of the most active and promising phases of research in the field of neoplastic diseases is concerned with the possible influence of nutritional factors. The large and important problems of mental and degenerative disease of the nervous system should be systematically explored from the standpoint of nutrition. The field of vitamin and enzyme chemistry is very closely related to the fields of chemotherapy and antibiotics. Nutritional research has contributed greatly to the progress of medicine and we may reasonably expect greater rewards from further studies. Such studies must be scientifically sound and in so far as possible based on objective methods of observation.

#### SUMMARY

Observations are reported relative to the detection of thiamin deficiency by assay of the thiamin content of blood. The importance of objective methods for evaluation of nutritional states is stressed. Such methods are needed for detection of subclinical deficiency, resulting from prolonged suboptimal nutrition and for detection of the earlier phases of deficiency disease which precede the obvious clinical manifestations. Such methods may be applied to surveys of population groups, in the evaluation of the possible rôle of nutritional deficiency in diseases of obscure etiology as well as in the management of individual cases. The rewards of nutritional investigations have been great and offer even greater promise for the future.

Medical Center, Third and Parnassus.

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*Murphy Button.*—With his flair for the dramatic and his frequent disputations on numerous medical issues, John B. Murphy was a colorful figure in the surgical world. The more of an audience in his clinic, the more perfect his technique. Always ready to advance in new fields where conservatives feared to tread, he soon gained the name of "stormy petrel of surgery." One of his biggest battles was against the scepticism of early diagnosis and operation in acute appendicitis. Though perhaps not seen by all, most physicians are familiar with the "Murphy Button."—*Warner's Calendar of Medical History*.

## LUMBOSACRAL SUBARACHNOID BLOCK\*

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THERE have been a number of different approaches used to block off the lower lumbar and sacral nerves. This paper will explain a method which was first introduced about six years ago by John A. Taylor, a urologist in New York City. The word "lumbosacral" refers to that area through which the needle is passed in doing this block, and likewise the area anesthetized, which is supplied by the lower lumbar and sacral nerves.

In reviewing the literature it is believed that this was the first time this approach was used in entering the subarachnoid space. However, it is possible that this site was not chosen before because it would be impossible to enter the spinal canal directly over this space. On examination of the skeleton it will readily be seen that the space which lies between the inferior surface of the 5th lumbar and the sacrum is the largest in the whole spinal column. The spinous process of the 5th lumbar overhangs this area and thus precludes any approach directly over this point in order to gain entrance to the canal.

In those cases in which there is a deviation of the spinous process of the 5th lumbar to one side, the space on the opposite side is thus increased, and the approach is made on this side. If one has access to the x-ray film before this procedure, it would naturally facilitate finding the best site of approach, but the operator does not always have this added information. In such a case the puncture is done the same as most spinals on the assumption that the structures are normal, and usually very little difficulty is encountered.

#### PREPARATION OF PATIENT

The preparation of the patient before coming to surgery is an important factor, and therefore it is the anesthetist's responsibility to examine the patient the night before surgery, and determine with what type of patient he is working, and order the proper medication. The preparation of the patient starts with 1½ to 3 grains of nembutal the night preceding surgery. In the morning 1½ to 3 grains of nembutal are given two hours before surgery. Then one hour later a hypodermic of Dilaudid, grain 1/32 or grain 1/20 with 1/200 of scopolamine is given. In the morning, after the medication, a mask is put over the patient's eyes, and cotton placed in the ears. These details seem to be commonplace, but they are valuable points in the success of the anesthetic.

#### POSITION OF PATIENT AND PROCEDURE

When the patient is placed on the operating table, he lies on his abdomen. The arms are placed above the head. A small pillow is placed in the lumbar area. Easy access to the canal is thus obtained by placing the patient in such a way that this area is as nearly level as possible. The skin is prepared with merthiolate or other antiseptic, and sterile drapes are placed around the field. The bony landmarks are then palpated; first, the crest of the ilium is located and an imaginary line drawn through to the opposite side will pass approximately between the fourth and fifth lumbar. Next the lowest prominence of the posterior superior iliac spine is palpated. A wheal is then raised about 1 cm. below and 1 cm. medially to this bony landmark. This site is about the location where entrance is gained to enter the 2nd sacral foramen.

At this point a few cc. of novocain are deposited both

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in the skin and deeper tissues. The spinal needle used is about  $4\frac{1}{2}$  to 5 inches in length, and 22 gauge. With the index finger resting on the spinous process of the fifth lumbar vertebra, the needle is passed through the wheal upward and medially, continuously pointing to the direction of the spine of the fifth lumbar. The upward angle is about 55 degrees, approximately the angle that the dorsal surface of the sacrum makes with the overlying skin at this point. The medial angle varies with the width of the sacrum, but the needle is so directed that it will be in the midline at the lumbosacral space. Care should be taken when directing the needle that it does not come in contact with the periosteum with much force as this may be a cause of much discomfort to the patient. In passing through the deeper structures the needle follows the course of the sacrum to the lumbosacral space. If the needle comes in contact with the bony structures its direction is changed slightly and advanced slowly and carefully. The sensations felt by the operator as the needle advances are about the same as one experiences in a higher puncture, and the characteristic feel is noted as the dura is penetrated.

In most cases as soon as the space is reached the spinal fluid appears, but not as forcefully as in the higher puncture in the side position. In some cases it is necessary to withdraw the spinal fluid. About 1 to 3 cc. of fluid are withdrawn, and to this 150 mg. of novocain and 5 mg. of pontocain are added, depending on the particular case and work to be done. This solution is slowly reinjected into the spinal canal. The response to the novocain is immediate. If a rectal operation is to be done, the patient is usually left in the same position; however any position can be used without harm to the patient if the rules of gravitation are applied the same as with the higher spinal. The blood pressure is recorded at short intervals and the patient should now be resting quietly. The Trendelenberg position can be used, the degree of which depends on the type of operation and other factors.

#### COMMENT

The advantages of this type of block are many. For most patients, lying in the prone position is much more comfortable than on the side in a flexed cramped position. However in some cases, when the patient cannot lie on the abdomen, the lumbosacral approach can be done with the patient on his side, but it is not necessary to flex the body to any great degree. This factor alone is of great advantage in obstetrical cases where a low block is desired for delivery.

This approach is of great value in those cases that are not able to bend their spine due to some pathological condition, such as arthritic changes or tuberculosis of the spine, or possibly a congenital bony defect.

This approach may be about the only method of procuring spinal fluid in meningitis and the accompanying opisthotonos. There is less fall in blood pressure and therefore less shock for the patient with this method. It is also a great advantage to the operator doing a prostatic resection not to have a great drop in the patient's blood pressure as all bleeding points can be stopped at the time of operation with no likelihood of hemorrhage from a rise in blood pressure after the patient has returned to his room. It is thus a safer anesthetic for the old and for those who are poor risks. Furthermore it is such an easy method that it can be used in the office without an assistant to hold the patient.

A review of one hundred of my cases done in a private hospital reveals the interesting fact that the average drop in blood pressure was only 10.8 systolic, and 6.5 diastolic. In fifteen cases there was no change in blood pressure. In a few cases one-half ampoule of ephedrine was used before injection. The average age of the patients was 67;

the youngest being 16, and the oldest 86 years. Only two patients had headaches which occurred shortly after surgery, but these could not be directly attributed to the anesthetic.

The cases in which this block was used were mostly urological; 48 cases were prostatectomies, transurethral, perineal, and suprapubic. There were cases of bladder fulguration, vasectomies, cystotomies. There were 19 hemorrhoidectomies and other rectal operations. The balance of the group included cervical biopsies, cauterizations, and various vaginal repairs. There were no complications of any notable degree recorded.

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#### PUBLIC HEALTH BACTERIOLOGY\*

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**B**ACTERIOLOGY and its allies (serology, immunology, mycology, parasitology, and virology) cease to become separate entities and merge under the larger field—Medicine.

It would be easy to indulge in histrionics to which the laboratory is so well adapted and which have so often been used. The creed of medicine has no place for histrionics and fantasy. We could presume, with pure speculation, that there must be a prize greater than the sulfa drugs and penicillin, just around the corner. There have been discoveries; there will be more.

#### PHYSICIANS IN RELATION TO PUBLIC HEALTH LABORATORIES

There are three general ways in which the relationship between physicians and the public health laboratories of tomorrow will be strengthened.

First—from these laboratories will come information which will give us a stronger hold on our knowledge of the etiology of infections. The background for much of our knowledge of diagnosis, treatment, and epidemiology hinges on an understanding of the etiology. This will help in many diseases, the etiology of which is not known or not understood. Differential diagnosis is increasingly difficult and dependent upon the laboratory. We are encouraged by glimpses of possible order to come in the confusing groups of diseases caused by viruses, rickettsiae, and yeasts and moulds. In the practice of a physician and in the epidemiologic control of infection, knowledge of the etiology has been a significant key in development. We may lose our grip on bacteriologic technicalities but we cannot afford to lose it on etiology and on diagnosis.

Second—we are sure to have significant technical improvements in the laboratories. We are likely to overlook the influence of these technical improvements on medical practice and public health. For example, there are thousands of culture media, and the adding of one or two more seems inconsequential. Wilson and Blair devised a medium which permits typhoid bacilli to grow as black colonies while almost everything else is inhibited. Leifson devised a desoxycholate medium and the Difco Laboratories prepared a *Salmonella-Shigella* medium known as SS medium. While these developments occurred some dozens of other culture media were added to the thousands that exist, yet the addition of these three has improved the quality of laboratory work in con-

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From the office of the Director of Public Health, City and County of San Francisco.

nection with enteric infection so much that epidemiologic data are changing.

The third of these general shifts is a change in attitude. The increasing complexity of our existence is forcing specialization, whether or not we approve. The day has gone when the physician was also an expert technician. He must turn over the burden of technical knowledge of the laboratory to the technicians and end the pretense of expert knowledge. He will have all that he can manage to learn how to secure specimens, when to get them, what to do with them, and how to interpret the reports sent to him from the laboratory. He will do well to give to the laboratory the information that it needs to examine specimens intelligently. He must learn to accept the decisions of the laboratory predicated upon its knowledge of the technique with which it deals.

The relationships between the physician, the epidemiologist, and the laboratory will improve with better coordination of effort. It takes the physician as long to handle specimens and reports from a poor laboratory as from a good one; it takes the laboratory as long to handle a useless specimen as a legitimate one. This wasteful gap needs reduction. We need to guard against the satisfaction that comes from taking a specimen, when that specimen is meaningless.

#### TENDENCIES IN OVER-CLASSIFICATION

One becomes dizzy at times with the present tendencies of bacteriologists to emulate the atom-cracking physicists. They are no longer content with a species of bacteria. They must needs divide them in groups, subdivide them into types, analyze these for genetic variants, check them for phase specificity, and then apply letters of half the alphabet to stages of their life cycles, somatic structure, flagellar components, virulence, and specific carbohydrate substance. If all this fails, there is the possibility of typing with bacteriophage. There are more than forty types of pneumococci; types of the medical students' anchor block, the typhoid bacillus, have passed the middle of the alphabet; and the varieties of *Salmonella* have reached astronomical figures. There are three kinds of diphtheria bacilli, if you look to your right; there are eight kinds, if you look the other way.

This chaotic condition is no more than a disorganized expression of the variation you see in your patients and designated as biologic flexibility. There have been no basic alterations in the principles of serologic reactions. The chemical, or antigenic, composition of organisms must vary almost from cell to cell. The only thing astonishing is the chaos of the descriptions. We can leave to the bacteriologists the argument about whether antigenicity should be used as a basis for defining varieties. Eventually bacteriologists will revert and reduce the number of kinds and everyone will be happier. The useful portion will then be more conspicuous. What is the useful portion?

Among the varieties of bacteria causing dysentery there have been only a few recognized types. Many physicians talk of Shiga, Hiss-Russell Y, Flexner, and Kruse. For sixteen years there has been talk of another type, isolated forty years ago by Duval—the Duval-Sonne type. This organism was overlooked for more than twenty years. It was present, it had been described, and only a short search was needed to identify it. For more than twenty years doctors sent specimens to the laboratory with inquiries about bacillary dysentery, often unrecognizable on clinical grounds alone, and received reports: "No dysentery bacilli found." Boyd, in England, has examined species from thousands of cases and has devised a cautious system of six definite groups, six more that he would like to study more before he defines them, and a couple of stubborn ones that will not fit in. Need

this throw our minds back in chaos? It need not. The chaos belongs to the bacteriologist. We do not care at all whether patients have Type II or Type VI paratyphenteric organisms, but we do care whether specimens we send in are positive or negative.

The epidemiologist is vitally interested in the confirmation of diagnoses. He has also another goal in which the private practitioner too often is not interested. He must trace the connections between cases. The many types of Boyd's dysentery bacilli and the endless types of pneumococci are short and simple compared to the *Salmonella*. We repeat that we are fortunately privileged to forget such thrills as the fact that paratyphoid C bacilli are listed as Roman VI, VII, indicating their somatic components; "c" indicating a specific phase flagellar component; and 1, 4 and 5 to indicate three group type flagellar components. We are interested in knowing that the organism is a *Salmonella* and not some organism resembling something else. Furthermore, the epidemiologist has a tool whereby he can trace a particular type of *Salmonella* to places circumstantially related in an epidemic. The chain which connects separate cases is tightened. A carrier is found in an area where cases of enteric infection have occurred. When the organism is a different type from the ones found in the surrounding cases the analysis of the epidemic changes entirely. This principle has been used in food poisoning and was used not long ago in California in connection with cases of typhoid fever from inadequately ripened cheese. It is the same as Sherlock Holmes' search for special kinds of tobacco. A knowledge of special blends led to the discovery of the murderer.

#### VIRUS INFECTIONS

Besides antigenic typing, serologic methods are being extended to diseases for which they were not used, notably in virus infections. How can anyone predict the Davidsohn test for infectious mononucleosis, the rH tests, or, for that matter, the Wassermann itself? Something is coming out of the bacteriologic escapades in serology. What about the laboratory and general sanitation? We have been confronted with technicians who dropped silk threads in disinfectants, made counts on milk, and looked for coli in water for so long a time that we may think these are settled issues. There is a legal difference between milk counting 10,000 and milk counting 15,000, but the accuracy implied is fictitious. Our concern is for safe milk, not quibbling over procedures which do not distinguish safe milk from unsafe milk.

#### SANITARY PROBLEMS

The advent of air-conditioning, the increase in use of ultraviolet light, and increased emphasis on respiratory infection may lead us to consider air in the same category with water and milk. We should then want the supportive aid of the laboratory. Couple together the Wells air centrifuge, selective culture media, several of which have already been suggested, and a respiratory organism like the alpha streptococcus or *Neisseria catarrhalis*, as numerous proportionally and nearly as frequent in the nose and throat as coli in the intestinal tract, and we have a procedure which health departments may one day find useful. Restaurants and beer parlors must raise the level of their sanitation. The public demands it. Sanitary inspectors face legal situations in making inspections and can use support from the laboratory as soon as this can be made available. A simple swab technique leads the way at present, but a few experiences in the courtroom of law and with lawyers will show you the complexities of relating science, pseudo-science, and human relationships. Not all of the difficulties are bacteriologic, yet a procedure which was sound scientifically and legally would be welcome.



Sanitation of foods is a part of this problem. We have mentioned *Salmonella*. There is likely to develop a series of procedures which will detect enterotoxigenic staphylococci. This would be helpful in tracing the sources of these staphylococci, now a source of conjecture.

#### IMMUNOLOGY

Immunology has for years been clouded and obscured by confusing its relationship with serology. Serology is concerned with reactions between antigens and antibodies. Immunology is concerned with resistance to infection, true immunity. The assumption that antibodies are the only means of preventing infection is gradually giving way. Antibodies sometimes are part of immunity but more often they are not. As explanations, they have failed more often than they have succeeded.

In the past few years, and just before the sulfa drugs and penicillin were so widely appreciated, there was increasing frankness in dealing with immunology. Men working with viruses discovered that most of them induced the formation of protective antibodies, detectable by their ability to neutralize the infectiousness of a suspension of virus experimentally.

The presence of these protective antibodies has often not correlated with the resistance to natural infection. This has led to the simple idea that an antibody results from an antigenic stimulus without necessarily any regard to immunity. The idea that antibodies must have a defensive function is anthropocentric, a teleologic concept. The idea of antigenic stimuli is old. Harmless bacteria and harmless substances induce the formation of antibodies as well as harmful ones. Typhoid vaccine is now thirty years old and with it our criterion for success has always been resistance to infection, true immunity, and not the presence of antibodies. Vaccination against smallpox is not presumed to depend on mere antigenic stimulus.

Biologic products are predicated upon the old concept of immunology, with one saving point only. The products are designed serologically but they must work effectively for the clinician; that is, immunologically. That is why there are so few widely accepted biologic products. A complete series of products could be made for every infection if only antigens and antibodies were considered.

The addition of sulfa drugs and penicillin to our armamentarium has diverted us from the old tenets of immunology that have hung on so tenaciously. The clinical success of these drugs, and perhaps tyrothricin or some yet to be discovered, is part of our immunologic future. They strengthen the case against traditional immunology and pave the way for a franker and less pompous attitude.

Finally, it should be evident from this short essay in the field of public health bacteriology how the practice of medicine has dominated its development. It is only by proceeding hand in hand with the medical profession that the public health official can win prestige and success. Health protection is a job of the health department and any scheme for sick care may react as an intrusion in a field in which our technical training may be inadequate. This may prove even hazardous to reputations when not working in the field of special competence and assuming the responsibility of others better equipped. It brings to mind the comment of W. Trotter in his *Collected Papers*, London, 1941, in which the curious but potential statement is made: "The lowly and junior profession of medicine, unlike its proud and elder sisters, has no direct influence in the work of government." The further statement is made: "The result is that, at a time when it is no longer possible to conceal the wholly unique importance of medicine for the very existence of social

life, our profession finds itself of all professions the least in command of social prestige, the least privileged, the most exposed, and the hardest worked."

#### CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH— 75TH ANNIVERSARY

This year we celebrate the 75th anniversary of the California State Board of Public Health. It may be of interest to all of you to know that the State of California had the honor of being the second Commonwealth in the Union to establish a State Board of Public Health.

It may be admitted that in our own brief lives we have become aware of the basic medical discoveries that have been made for increasing the life span and the happiness of mankind.

101 Grove Street.

#### FREE ENTERPRISE AND THE DOCTOR\*

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SICKNESS insurance touches the lives of people so intimately and in theory is so tempting that it is always one of the first baits offered by planners for a socialized state. Bismarck introduced it into Germany in 1883; Lloyd George into England in 1912. In each case it was part of the rise of bureaucracy and the decline of representative government. It is one of the means by which men greedy for power gain control over the people and destroy their freedom. It is often said that liberty without subsistence is worthless. Franklin said that those who would trade freedom for subsistence are worthy of neither.

Americans hold liberty a priceless possession. When threatened by a foreign invader we spend life and treasure unhesitatingly. More slowly do we recognize the poison of foreign propaganda. Much contempt has been poured on the American system of economy. Never in history has any nation come so close to the four freedoms as ours, under the system of free enterprise. It is not by accident in our land that so many have so much. Freedom is a kindly soil for pioneering and for creative genius. Incentive causes men to take risks and to work more productively and enthusiastically than any slave.

#### ADVANTAGES OF FREE COMPETITION

True, abuses need to be corrected, monopolies curbed, wealth distributed. But we have the procedure within our constitution, and its two-party system to correct abuses. We have labor unions to bargain for their rights. We are not slaves. How then do we listen to the siren song of the socialized state which, Hayek has shown, leads directly to totalitarianism. We realize that some of our people do not have adequate food or housing or medical care. Does that prove that bureaucracy would be better? Russia before the revolution was not a starving nation. But after twenty-five years of totalitarian management, during which many millions starved, the general standard of living, despite lavish natural resources, is less for nine-tenths of its people than for our lowest tenth on relief during the depression. To curb the source of our wealth by bureaucratic control will leave less to distribute. The ultimate result will be not to make everyone rich but to make everyone poor. Capitalism is incompatible with totalitarianism because it connotes freedom. Freedom to purchase at the most favorable rate means competition. Competition by causing the failure

\* Chairman's Address. Given before the Section on Urology, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

of inefficiency saves waste. Our railroads in the first war were under government management to avoid competition. They cost the government a great deal of money and the service was poor. In this war a vastly better job has been done; the railroads have rehabilitated themselves and paid the government millions in taxes. Every dealer in a commodity, whether merchandise or medical care, is stimulated by free competition. With bureaucracy less of the doctor's time will be available for service. The province of government is to hold monopoly in check and promote fair competition.

#### ON PROPAGANDA

We should be wiser and more alert to the deceit of clever propaganda. We should realize that the party line of all totalitarian states not only tolerates but demands of its agents an utter disregard for truth. They aim at world domination. The end justifies the means. They confuse the meaning of words. We call ourselves a democracy—that is, rule of the common man. All the totalitarian states are essentially the same—rule by the few. Yet Russia calls itself democratic. The first line of totalitarian propaganda against real democracies is to talk down a representative government and ridicule the legislators. In 1929, Lord Hewart, Lord Chief Justice of England, published his book, "The New Despotism," where he describes in detail the process by which power was being transferred from Parliament to bureaucracy and placed beyond the jurisdiction of the law courts. The process Lord Hewart described has made an appalling progress since he wrote. Parliament is now openly derided as an ineffective "talking-shop" whose sole remaining function is to transfer the remainder of its sovereignty to the experts "so obligingly infiltrated into the Civil Service from the London School of Economics training ground." (See the *Weekly Review*, July 20, 1944).

The final step is to win some intelligentsia by the promise of leadership and liquidate the rest. Freedom of religion goes. The unthinking masses are taken over by glowing cradle-to-the-grave promises or intimidation by secret police. Foreign exchange, travel and news is controlled. Youth segregated, indoctrinated and welded by hate grows into a fanatical army. We have seen this develop in many countries. With the tragic vision before our eyes of the downfall of a great, once liberal nation which followed socialism to its bitter end, we should be well warned.

#### WHY PHYSICIANS OPPOSE STATE CONTROLLED MEDICINE

Why does the doctor the world over oppose state controlled medicine? It is easy for many persons to jump to the conclusion that the physician opposes because it may curtail his income. However, the average income may be just as high with state medicine as without. The doctor opposes it because political control and restrictions so hedge him about that he cannot practice the scientific medicine which he has been taught. The system is frozen by regulations; therefore he deteriorates instead of growing better. From the patient's point of view, the greatest objection is the third party, the state, coming between him and his doctor. This is a bitter complaint in England. The doctor is divided between his duty to his employer, the state, and to his patient, who never knows whether he is getting disinterested advice. State medicine is practically always a part of a comprehensive socialized system by which the doctor has two functions: (1) Medical care and treatment; (2) Certification for cash disability payments. This situation greatly aggravates the doctor's troubles. It takes his time and

he pleases neither his state administrator nor his patient. The German notes in the *Journal of the American Medical Association* before the war stated that cash benefit certification occupied half of the doctor's time.

#### PANEL SYSTEM OF ENGLAND

England has the panel system. A doctor may have up to 2,500 patients, more likely 1,500, for whom he gets \$2.25 per person per year. Dependents are not covered but the same doctor generally cares for them at a low fee. The doctor keeps an office hour from 9:00 to 10:00 in the morning and from 6:00 to 7:30 in the evening. There will be 20 to 60 people in during each time for medical service or certification for cash benefits. He must see them all. He must take out the record in each case, make his diagnosis, sign a certificate or a prescription and make his clinical notes on the card. Thirty persons in an hour and a half allows three minutes per person. The record is a card 7 inches by 5, ruled in lines. An inch is devoted to date,  $\frac{3}{4}$  inch indicates office or house visit or cash certification. Two and a quarter inches are allowed for clinical notes and the final inch for diagnosis. No space is allowed for treatment, so that for diagnosis is used. There is an average of one prescription per person each time he calls on the physician.

The regulations provide that "The clinical purpose of the record is to contribute to the efficient treatment of insured persons by preserving in permanent and readily accessible form records of such clinical data as are likely to be of assistance to the practitioner or other practitioner under whose care the patient may subsequently come." You may judge how nearly the system comes to its aims. If the doctor's panel is 1,000 or more he may have from 20 to 50 house calls. It was stated in the *Journal of the American Medical Association* the year after state medicine was inaugurated in England the consumption of narcotics was doubled. This is a panel practice. If the patient is too ill to be cared for at home the panel doctor refers him to a hospital and is not then responsible. He does not follow the patient in the hospital, nor does he generally get a report from the hospital when the patient is discharged.

#### OTHER EUROPEAN PLANS

The general practitioner becomes harassed and inefficient. I was told in Germany in 1930 that only 3 per cent of the physicians in Germany were in private practice. The reward is so little that the ablest students do not elect medicine. In Russia they had to be conscripted. It is unnecessary to say that poor medicine is expensive medicine. Workmen's compensation administrators have found this out.

The income bracket under \$1,500, which comprises most of the workers of western Europe, is covered by sickness insurance, both for medical care and cash disability indemnities. When once the plan has been inaugurated, however unsatisfactory, it cannot be abandoned because of the contractual obligations to those who have paid premiums. The funds have seldom allowed for medical progress, so that there is always an insufficiency for modern medical care. Some funds have not yet allowed x-ray, insulin, liver therapy. Most of the income group covered would be eligible to a better standard of medical care free in this country. In fact, the standard is so far below American expectations that the fund would have to be much larger to cover acceptable care here.

In 1938 J. G. Crownhart made a six months' study of sickness insurance in Europe. He was sponsored by many



notable, socially minded people, including U. S. Senator Robert M. La Follette, Dr. Frank G. Boudreau, Medical Director of the Milbank Fund, and recently Director of the Health Section of the League of Nations, Isador I. Falk, Chief of Division of Health Studies, United States Social Security Board, and others. I am indebted to this study for information used in this paper and quote his summary:

"The theory of sickness insurance and the practice are entirely different.

"There can be no certainty that the premium is adequate or will remain so, as the demand for service is not susceptible to actuarial computation.

"The primary responsibility of the physician is to the government and not to his patient.

"Premiums once established are rarely changed.

"State systems provide opportunity for political control.

"The rôle of sickness insurance in Europe is salvage.

"The system loads the physician beyond his capacity to render a sound quality of sickness care.

"Free choice always has limitations.

"While the theory of sickness insurance indicates its use as a powerful weapon in disease prevention, there is no indication that it has ever occupied that rôle.

"The constant effort in sickness insurance is to devise ways and means of delivering the benefits that the theory envisions but the practice inhibits."

#### IN CONCLUSION

It is the duty of the physician as a citizen to make known to the public the fact that medicine heretofore rendered in Europe under comprehensive health insurance is greatly inferior to what American citizens have been taught to expect, even in free clinics. The public should also know that politicians in foreign countries have used this as one of the early baits for a progressively socialistic state which has, in more than one case, ended in totalitarianism and disaster.

65 North Madison Avenue.

#### MEDICAL EPONYM

##### *Gilbert's Disease*

This was first described by Professor A. Gilbert (1858-1927) at a meeting of the Société médicale des hôpitaux de Paris on July 27, 1900, in a paper entitled "De l'ictère familial: contribution à l'étude de la diathèse biliaire [Familial Jaundice: A contribution to the study of the biliary diathesis]," in collaboration with Drs. J. Castaigne and P. Lereboullet, in which a number of cases of jaundice of diverse origin are described. Their paper appeared in *Bulletins et mémoires de la Société médicale des hôpitaux de Paris* (17:948-959, 1900). A portion of the translation follows:

Whatever else the nature of this hereditary predisposition to infection of the biliary passages may be, it seems to us to be proved by the facts that we have reported. Not only lithogenic angiocholecystitis, then, is hereditary; simple or cirrhotogenous angiocholitis may equally be so, and by reason of this predisposition, one may meet in a single family with the various clinical types, the principal characteristics of which we have described.

In subsequent papers he further describes simple, non-hemolytic familial jaundice—for example, in an article entitled "La cholémie simple familiale [Simple Familial Cholemia]," in the *Gazette hebdomadaire de médecine et de chirurgie* (7:889-897, 1902), he states: "Familial cholemia is extremely common. . . . It is a familial, hereditary disease."—R. W. B., in *New England Journal of Medicine*.

## THE ROLE OF THE GALLBLADDER IN DISEASE OF THE LIVER\*

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THE rôle of the gallbladder in production of disease of the liver is a matter of some controversy and disagreement. Nevertheless, this relationship does exist in some cases. Its occurrence, however, is infrequent and confined to certain complications of cholecystitis and the presence of neoplasms of this organ.

#### STUDIES OF GRAHAM, JUDD AND OTHERS

Our attention to this problem was first drawn by the work of Graham,<sup>1,2</sup> who from his pathological and experimental studies seemed to prove that inflammatory changes in the liver constantly occurred in association with cholecystitis. He believed that cholecystitis originated from infections in the liver which reached the gallbladder either by a hematogenous route or by the way of the lymphatics going from the liver to the gallbladder wall and later to its mucosa. The type of pathological reaction described as hepatitis by Graham which was supposed to be the origin of the infection causing the cholecystitis, was an infiltration surrounding the portal vein and its branches in the stroma of the liver, consisting of an increase in the production of the fibrous tissue of the stroma together with a cellular exudate characterized by mostly lymphocytes and plasma cells and a scattering of polymorphonuclear leucocytes. This picture came to be known as periportal infiltration or periportal hepatitis and later on interstitial hepatitis. The later observations of Judd, Nickel and Wellbrock,<sup>3</sup> and later by Judd<sup>4</sup> in another paper, also emphasized the origin of cholecystitis by the lymphatic spread from the liver. Here then appeared to be evidence that the liver was probably the primary seat of infection which gave origin to cholecystitis rather than that cholecystitis gave origin to disease of the liver.

While the conclusion of Graham, Judd and others were accepted by many, they were open to question because it appeared from the work of Rous and McMaster<sup>5</sup> and Harrar, Hargis and VanMeter<sup>6</sup> that lymphatic spread does not occur from the liver to the gallbladder as Graham and Judd stated, but rather from the gallbladder to the liver. Furthermore, other experimental studies showed that infection of the gallbladder occurred by the way of the cystic duct by means of infected bile. Wilkie<sup>7</sup> found that cholecystitis did not occur if the cystic duct was ligated, and furthermore, that after the production of acute cholecystitis by this method no hepatitis resulted if the gallbladder had been freed from its attachment to the liver, indicating that infections might spread from the gallbladder by way of the lymphatics to the liver.

#### OTHER STUDIES

On the basis of these experimental findings and from their own study of 27 cases of cholecystitis, Koster, Goldzier and Cullen<sup>8</sup> in 1930 turned squarely about from the position of Graham, Judd and others and stated that they believed that liver changes when they occurred were secondary to cholecystitis and inferred that the gallbladder originally may have been infected by bile containing organisms excreted by the liver. This relationship Koster and his associates believed could be reconciled to the clinical observation that patients with long-

\* Read before a joint meeting of the Sections on Medicine and Surgery at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945. One of four papers in a panel discussion on Diseases of the Liver.

standing gallbladder disease because of the remaining hepatitis are less frequently and completely relieved of their symptoms by cholecystectomy than those in whom the disease has been of shorter duration. This conception they believed constituted a plea as well for the earlier surgical treatment of gallbladder disease in order to prevent further spread of the infection with the production of disease of the liver.

#### COMMENT

While there are valid objections to the theory of Graham, there are also valid objections to the opposite view held by Koster and his colleagues, for were the view of the latter investigators true, then those people afflicted with cholecystitis with gallstones for a number of years would certainly be expected to have a complicating hepatitis which in turn might be expected to give them trouble after the removal of their gallbladder but, as pointed out by Martin,<sup>9</sup> this is usually not the case unless there has been some involvement of the common duct.

A further criticism of the deductions from their studies is that after all this periportal infiltration is not necessarily specific for cholecystitis but as Kahlstorf,<sup>10</sup> Kettler,<sup>11</sup> and Noble<sup>12</sup> showed in their necropsy studies it may occur not only in disease of the biliary tract but in chronic or acute disease of the gastro-intestinal tract and in 92 per cent of general infections, and is of no probable clinical significance.

Finally a paper by Colp, Doubilet and Gerber<sup>13</sup> in 1935 reviewed this whole subject, and like Koster and his colleagues, these investigators took tissues from the liver at some distance from the gallbladder or biliary tract since it was recognized that liver tissues immediately adjacent to the gallbladder might show evidence of localized inflammation, probably from direct extension from the gallbladder. These tissues were later sectioned and studied very carefully by special cytologic stains. From their studies they concluded that "Periportal infiltrations observed in biliary tract disease are not specific for the disease but represent a reaction of the liver to extra-hepatic infection. Hepatitis is not an accompaniment of cholecystitis, as evidenced by the absence of inflammatory and parenchymal changes in the liver."

In summary of these various viewpoints, it may be stated that we have passed through three stages of thought, the first expounded by Graham, that cholecystitis was considered secondary to primary liver disease, to a second stage and opposite view by Koster and his associates that cholecystitis was the primary disease and hepatitis the secondary involvement, to the third stage in which the pathologic changes described both by Graham and Koster are believed by Martin, Noble, Kettler, Kahlstorf, and by Colp and his associates, to have no relation whatsoever in the production of either cholecystitis or hepatitis and that these pathologic changes are not specific for any particular infection and are of no clinical significance.

All of this would seem to be very well except that there are still to be considered certain complications of cholecystitis as well as the presence of neoplasms of the gallbladder, representing primary disease of the gallbladder, which do produce secondary disease of the liver. The relation of gallbladder disease, therefore, to production of disease of the liver concerns us with a consideration of the complications of cholecystitis and later of primary neoplastic disease of the gallbladder.

#### COMPLICATIONS OF CHRONIC AND ACUTE CHOLECYSTITIS

*Perforation of the gallbladder* occurs much more frequently in acute cholecystitis or subacute cholecystitis than it appears as a complication of chronic cholecystitis.

It may occur in acute infectious cholecystitis without stones but much more often in gallbladders containing gallstones. In about eighty-five per cent of the cases gallstones may be present either in the bladder itself, or especially in the cystic duct and in about 20 per cent of the cases in the common duct.

Since gallstones are present therefore in most of these cases, there is usually a preceding history of symptoms suggesting chronic cholecystitis or biliary colic from the passage of other gallstones. When the acute attack, however, sets in, it may develop with marked rapidity. The symptoms are chiefly those of upper abdominal pain with some rigidity, nausea and vomiting. The pain may be mild or dull but it is sometimes severe and for the most part situated in the right upper quadrant with some radiation around to the back under the right shoulder blade. There is a feeling of bloating due to a sensation of fullness in the epigastrium and while attempts are made to relieve this by vomiting, it is usually without avail. These patients run an elevation of temperature which varies anywhere from 100° to as high as 105° Fahrenheit in those having gangrene and perforation of the gallbladder. There may be a suggestion of icterus from the appearance of the sclerae but in most cases there is no jaundice unless there is an associated cholangitis.

Physical examination discloses an uncomfortable patient who may be nauseated and vomiting. On examination of the abdomen by palpation there is extreme sensitivity and tenderness over the gallbladder area and a definite sense of rigidity of the abdominal muscles. Deep pressure produces more severe pain and sometimes a distended gallbladder may be palpable although usually not because of the rigidity of the abdominal muscles.

The laboratory findings are of definite value in that they show a marked leucocytosis which may range from 18 to 30,000 in cases where a suspected gangrene or perforation has occurred. The icterus index may at first be normal but if there is any extension involving the liver, either as cholangitis or later by abscess formation, the icterus index may be slightly elevated, even to the point of clinical jaundice.

Perforation of the gallbladder may be suspected in those cases of acute cholecystitis which do not respond to conservative treatment but in which the white count increases and the temperature continues to remain high along with increasing pain and rigidity in the right upper quadrant.

Following perforation there is the production of a localized peritonitis with abscess formation which may be located in the region of the fundus of the gallbladder or in the region of the cystic or common duct. Generally this abscess may be walled off by the omentum and only rarely does it result in a generalized peritonitis. The abscess cavity may contain one or more gallstones should gallstones be present. Further progress of this complication of acute cholecystitis is in the extension of the abscess to involve the liver substance itself. While this occurs very rarely, it is something to be on the watch for and may be suspected when the patient begins to have daily chills in addition to the high fever he is running. With extension into the liver a single abscess may result or multiple abscesses, from the presence of cholangitis, in which case the patient may be jaundiced.

As to the frequency of perforation, Zollinger<sup>14</sup> in 1941 reported that perforation occurred in 16 or 13 per cent of 121 cases of acute cholecystitis. In another series of 84 cases of acute cholecystitis reported in 1942 by Glenn and Moore,<sup>15</sup> 22 of them or 26 per cent had perforation of a gangrenous gallbladder, with abscess formation.

#### TREATMENT

It is advisable that cases of acute cholecystitis be hospitalized at once so that their progress may be closely



watched in the next few days when the issue of operation must be faced. Many cases of acute cholecystitis will begin to subside after two or three days of treatment in the hospital while others are more stubborn and the condition may become progressively worse as these cases go on to perforation. The patient should be confined to bed with hot applications to the right upper quadrant. Glucose solutions are given intravenously up to 2000 cc. daily. The diet is generally a bland diet high in carbohydrate and protein, and low in fats. Any distention of the abdomen may be relieved by enemas, intermittent Harris flush or sometimes by saline laxatives. The pain may be controlled by either morphine with atropine or demerol hypodermically. The patient is watched carefully and frequent or daily blood counts are made to watch the direction of the leucocytosis. Likewise the icterus index may be taken to detect the development of jaundice which may later become clinical and signify involvement of the liver by cholangitis.

I believe it is advisable in all cases of acute cholecystitis treated in hospitals that penicillin be administered at once. It is well to start with 20,000 units every three hours while the temperature is high and as improvement occurs the dosage may be reduced to 10,000 units every four hours. Penicillin may be a life-saving measure in exceedingly obese patients especially if they are late in coming to the hospital after the onset of their illness, for this fact with their obesity increases the surgical risk.

If, as a result of hospital medical treatment with penicillin, intravenous fluids, hot compresses, etc., the patient makes a good recovery, surgery then may be postponed, but a much better plan is to wait seldom longer than two to four days when one finds that the patient is not making satisfactory progress, as indicated by a high temperature, increasing leucocytosis, pain, and rigidity. In such cases the gallbladder may have perforated with the production of a local abscess. When cases are operated cholecystectomy and drainage with search of the cystic and common ducts is the operation of choice, but if the gallbladder is too gangrenous and friable and the patient obese and very sick then cholecystostomy and drainage should be the only surgery performed. While the opening of the common duct in a search for stones is associated with a higher mortality, Zollinger believes that the mortality is not as high as that which would follow with a second operation for the removal of these stones.

In those cases in which the abscess formed by perforation of the gallbladder extends into the liver to form a solitary abscess there, cholecystectomy or cholecystostomy with further drainage of the abscess cavity is usually sufficient, but when multiple abscesses occur adequate drainage is usually impossible and in these cases the adjunct treatment with penicillin may be of life-saving service to the surgeon and patient.

The appearance of perforation therefore in acute cholecystic disease is one of the complications of cholecystitis which may lead to the production of liver disease either by the formation of local or multiple abscesses.

#### CHOLANGITIS

The second complication of acute cholecystitis which leads to disease of the liver is cholangitis. While this disease of the biliary ducts may be a primary disease of the liver caused by an infection which may be either blood-borne or ascending from the duodenum or descending with the bile from the liver, it may develop as an extension from an acute inflammation of the gallbladder or following obstruction of the common duct due to stones.

In a series of acute non-calculous cholecystitis reported by Wolfson and Rothenberg,<sup>16</sup> eight or 25.8 per cent of the cases had cholangitis as a complicating feature of

acute cholecystitis. In another series of cases reported earlier by Blalock,<sup>17</sup> 38 per cent of the non-calculous cases of acute cholecystitis were complicated by cholangitis and 44 per cent in the calculous cases of acute cholecystitis, thus indicating that this complication may be equally frequent in cases of acute cholecystitis either with or without stones.

The inflammation of the bile ducts in cholangitis may be mild and persistent, representing mostly hyperemia and edema of the bile duct mucosa without any evidence of pus. However, in other acute cases of cholangitis the inflammation may go on to suppuration with the presence of free pus in the bile ducts leading to multiple abscesses of the liver. These multiple abscesses are generally bile stained in contradistinction to multiple abscesses formed in the liver in cases of pyelephlebitis. The inflammation of the bile ducts results in many of the bile passages being occluded, producing stagnating bile in the liver leading to enlargement of that organ and the production of an obstructive type of jaundice. The most common organisms isolated in these cases of cholangitis are the bacillus coli, streptococci, staphylococci, and bacillus typhosus.

In addition to the symptoms which indicate the presence of an acute cholecystitis, such as pain, tenderness and rigidity in the right upper quadrant, temperature of 101° to 105° F., sustained or increasing high leucocytosis, the appearance of jaundice is the new sign that indicates the presence of acute cholangitis. Chills may also occur in addition to the presence of jaundice and fever.

The jaundice is mostly obstructive in character, but the associated hepatitis which occurs with the infection of the bile ducts often permits some bile pigment to enter the blood stream directly, in which case a biphasic Van den Bergh reaction may occur and both bile and urobilinogen are present in the urine. The amount of jaundice will fluctuate from day to day as indicated by varying degrees of brown color of the urine and the amount of brown pigment coloring the stools.

It is sometimes very difficult when seeing these cases for the first time when they are already jaundiced, to know whether or not we are dealing with a hepatitis of the simple catarrhal or epidemic form, or whether we are dealing with jaundice due to the occlusion of the common duct by stone, or, by extension of an infective process from acute cholecystitis. In these cases the medical history may afford some suggestion of previous symptoms which indicate cholecystitis, such as painful cholic, recurrent bouts of fever and previous attacks of jaundice. In such cases one might reasonably be sure then that the acute cholangitis is superimposed upon an old chronic or an acute cholecystitis with or without a common duct stone. When the history does not clearly give evidence of previous cholecystic disease, the case may have to be observed for some time before one may reasonably make up his mind as to what is the etiology of the jaundice.

Whenever acute cholangitis occurs as a complication of acute cholecystitis the indications for treatment are the same as those of acute cholecystitis without complicating cholangitis, that is, the same medical measures and later surgical intervention with removal of the gallbladder if possible or otherwise cholecystostomy with exploration of the common duct and adequate drainage since it is the cholecystitis that represents the primary focus of infection which has spread to the liver. Surgical intervention alone may result in a complete cure of the complicating cholangitis, but it is desirable as stated before to use penicillin also. Furthermore in cases in which it is certain that biliary obstruction is not complete as evidenced by the presence of bile in the stools and urobilinogen in the urine, the administration of one of the dehydrocholic

acid preparations may help to wash out the infection by producing increased drainage of bile from the liver.

#### MALIGNANT TUMORS OF THE GALLBLADDER

Malignant tumors of the gallbladder are of importance so far as the liver is concerned because of their extension and spread into the liver. Primary malignant tumors of the gallbladder are chiefly carcinomas and more rarely sarcomas. It is estimated that cancer of the gallbladder constitutes approximately five or six per cent of all cases of carcinoma of the human body. It occurs more frequently than does cancer of the bile ducts themselves. In a series reported by Deaver and Bortz<sup>18</sup> in a study of 903 cases of gallbladder disease, cancer was found in 1.5 per cent. In another series reported by Smithies<sup>19</sup> of 1,000 cases of gallbladder disease, cancer occurred in 2.3 per cent, or 23 cases.

Cancer of the gallbladder occurs more frequently in women than it does in men, undoubtedly due to the fact that gallstones occur more frequently in women than they do in men, for it has been shown that anywhere from 60 to 95 per cent of the gallbladders with carcinoma also contain gallstones. Therefore, it appears that the presence of gallstones in such a high percentage of gallbladders with carcinoma has something to do with the production of the carcinoma, and it was the theory of Ewing<sup>20</sup> that "mechanical irritation of calculi, the relation to a peculiar form of lipid metabolism (cholesterol), and the irritative and digestive action of bile, seem to combine in producing the remarkable susceptibility of the mucous membrane to cancer."

The types of cancer found in the gallbladder may be represented by a fungating growth, a gelatinous type and a diffuse scirrhous type of carcinoma, with metastasis occurring especially to the liver.

Because of the presence of gallstones in the majority of carcinomatous gallbladders, there is usually a preceding history of symptoms that suggest cholecystitis. There may be tenderness in the right upper quadrant in the area of the gallbladder and later on in this area a palpable mass may be made out in some of the cases. Jaundice occurs chiefly as the result of massive metastasis to the liver, or when it is associated with a chronic cholangitis from the presence of obstructive stones in the common duct. Ascites may occur later on in the course of the disease if there is considerable pressure upon the portal vein by metastatic growth.

Fever may be present. In the case of cholangitis it may reach 102° or 105°F. and when cholangitis is absent it is apt seldom to run over 100° to 101°F. There is generally pain in the area of the gallbladder which may be felt upon stooping over or upon pressure with the hand and may radiate around to the back. Sometimes it develops upon taking a deep breath. At other times the pain may be accompanied by colic which may be severe and radiate around to the back, upward into the right shoulder. The presence of a hard nodular painful tumor in the region of the gallbladder associated with loss of appetite, loss of weight and anemia, and a history suggestive of previous cholecystitis may well be the basis for a presumptive diagnosis of carcinoma of the gallbladder. However, when the carcinoma is of the scirrhous type it may not be palpable. X-ray diagnosis may reveal the presence of gallstones if some dye passes into the gallbladder but too often the gallbladder is non-functioning and unless the stones contain calcium they will not be opaque to x-rays and therefore visible. Finally a diagnosis is only certain by surgical exploration and the examination of the gallbladder.

Surgical treatment provides only slight hope of cure in those cases which are operated upon before there is evidence of metastasis, and if metastasis has occurred, then

surgery should be limited to simple exploration and closure.

Primary sarcoma of the gallbladder is very rare and deserves very little consideration here since its symptomatology does not differ characteristically from that produced from carcinoma of the gallbladder.

#### SUMMARY

In the past twenty-five years we have seen a period of many experimental, pathological and clinical investigations describing a particular kind of hepatitis known as periportal inflammation. Some investigators attempted to associate this hepatitis with cholecystitis either as the cause of it or as the result of cholecystitis, but now the general opinion is that the hepatitis results from many general infections. However acute cholecystitis may lead to disease of the liver whenever the complications of either perforation with abscess formation or cholangitis occur. Also primary malignant tumors of the gallbladder spread to the liver. By these means the gallbladder plays a rôle in the production of disease of the liver.

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*Ménière's Disease.*—The well-known French otologist, Prosper Ménière, was a follower of the school of J. M. G. Itard. He is best remembered by the syndrome to which his name has been given. Besides his scientific contributions on the anatomy and affections of the ear, he wrote books and articles that bear such interesting titles as "Cicéron as a Doctor," "Consultations of Madame de Sévigné," and "Medical Studies on Latin Poets."—Warner's *Calendar of Medical History*.

A stomach that is seldom empty despises common food. (Jejunus raro stomachus vulgaria temnit.)

—Horace, *Satires*. Bk. II, sat. 2, 1. 38.



## INFECTIONS OF THE LIVER WITH SPECIAL REFERENCE TO AMEBIASIS\*

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TWO important changes in our basic philosophy concerning amebic infection of the liver are responsible for the recent marked lowering of mortality and morbidity in this condition as noted in many reports of considerable series of cases now appearing in the literature:

1. Recognition that amebic hepatitis and amebic hepatic abscess constitute a special kind of liver necrosis<sup>1</sup> produced by the invasion of a micro-organism, the *endameba histolytica*, for which there is a specific remedy, emetine. The situation is comparable to the development of a gumma in the liver caused by the *spirochaeta pallida* against which the arsenicals and bismuth are specific.

2. Repeated demonstration that where, because of pyogenic infection complicating amebic hepatic abscess, open drainage of such abscess is required, it is absolutely imperative that such drainage be performed in a manner to avoid contamination of pleural or peritoneal cavities.

Renewed emphasis falls upon amebiasis at this time because of military operations conducted throughout the world, but particularly with reference to tropical contacts. That amebiasis is not a tropical disease but is widely prevalent in this country has long been recognized by gastro-enterologists. Craig<sup>2</sup> estimated that from five to ten per cent of our population harbor the ameba in the intestinal tract, while Faust<sup>3</sup> places this incidence at about twenty per cent. It is believed that four to five per cent of those so infected will present hepatic complications. Thus, if Faust's figure of twenty per cent infestation for our population is accepted, some twenty-five million instances of amebiasis may be said to be present in this country with the probability that something over a million of them will develop amebic hepatitis or amebic hepatic abscess. Should there be any increased infection rate on the general population as the result of the importation of ameba from our military contacts, these figures would naturally have to be revived upward.

### PATHOLOGY

*Etiology.*—All authors stress the predominance of males to the extent of 50-95 per cent in amebic hepatic involvement, and the ages most commonly affected as the second to the fifth decade. Probably all instances are preceded by involvement of the colon, but such involvement may antedate the development of liver complications by a few days, months or even years, and such colonic involvement may be entirely asymptomatic in as high as 50 per cent of the cases.

*Pathogenesis and Pathology.*—The ameba may invade the liver by (1) direct extension through the bowel wall and peritoneal cavity; (2) through the lymphatics; (3) through the portal vein, the last route being by far the most common. Intrahepatic portal thrombosis occurs directly as the result of amebic action; the ameba also have a direct cytolytic activity on the liver parenchyma. The process may be arrested at this early stage either by treatment or spontaneously in certain instances, or it may progress to the formation of true abscess in which there is a central area of colliquative necrosis surrounded by a thick fibrous capsule. The uncomplicated amebic abscess is sterile, and upon this important fact is based our rationale of treatment.

Abscesses are usually single, occur most often in the

right lobe and usually in the dome of the right lobe. However, multiple abscesses may occur and infrequently abscesses are present in the left lobe of the liver. Associated pathological features consist of secondary infection of the abscess with pyogenic cocci and/or the colon bacillus; rupture of the abscess into the subphrenic space, the subhepatic space, pleural cavity, lungs, bronchus or general peritoneal cavity.

### SYMPTOMS AND SIGNS

The symptoms and signs vary in intensity and degree depending upon whether the condition is acute, subacute or chronic in its onset. Typically, there are low grade intermittent or remittent fever, pain in the right upper abdominal quadrant, sometimes referred to the right shoulder, chills, and in the severe instances with complicated abscesses, drenching sweats. There may be a subicteric tint to the skin. The abdominal findings consist of rather well defined tenderness over the right upper quadrant, together with some degree of enlargement of the liver. Infrequently an abscess may be felt pointing below the right costal margin. In the instances where the abscess is in the posterior portion of the liver on the right side there is tenderness over the eleventh and twelfth intercostal spaces and the right costo-vertebral angle.

*Laboratory Findings.*—In the uncomplicated hepatitis or amebic abscess, there is a moderate leucocytosis without a concomitant increase in the polymorphonuclear leucocytes. Typical counts vary from thirteen to sixteen thousand white blood cells per cubic millimeter with polymorphonuclears between 70 and 75 per cent. The finding of the ameba *histolytica* in the stool in such a patient is practically diagnostic, but the percentage of positive findings varies over so wide a range in proved cases of amebic hepatic involvement that negative stool findings are not to be considered too seriously. Fluoroscopic and x-ray examinations are particularly important in diagnosis. The right sheath of the diaphragm is elevated and fixed and there is usually obliteration of the anterior costophrenic and cardiophrenic angles.

### DIAGNOSIS

Diagnosis is based upon a careful history involving the onset, related intestinal disturbances, physical signs as above described, together with corroborative x-ray and other laboratory findings. Inasmuch as the treatment depends very fundamentally upon the nature of the condition of the liver, whether it be hepatitis, uncomplicated abscess or an abscess secondarily infected with pyogenic organisms, too great care cannot be exercised in establishing this point before treatment is instituted. Other conditions to be considered are: subphrenic and subhepatic abscess due to gastric or duodenal perforations; infections of the gallbladder, infections of the urinary tract, chronic pulmonary disease such as tuberculosis or lung abscess; brucellosis, septicopyemia from whatever cause; pylephlebitis with multiple pyogenic abscesses of the liver. In each of these conditions, appropriate history and confirmatory laboratory data are sought and evaluated.

### TREATMENT

Practically all cases of amebic hepatitis and many instances of uncomplicated abscess will respond to emetine therapy alone. This drug is given as emetine hydrochloride intramuscularly or intravenously, one grain daily for a period of from six to ten days.

Should such a course of treatment not result in marked improvement, aspiration of the abscess is indicated. As stated previously, uncomplicated amebic abscesses are sterile and it is extremely important that no infection be introduced from without. Therefore, the

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technique of aspiration should be performed under strict aseptic conditions, preferably in an operating room where if the aspiration presents indication for it, further and more extensive drainage may be undertaken at once. Aspiration should be performed directly into an abscess that presents below the costal margin. If the abscess is not palpable, but has been localized by fluoroscopic and x-ray examinations, there are three usual sites of such locations and three methods of approach.

First, for an abscess located in the anterior portion of the liver, the needle is inserted below the anterior costal margin about 4-6 cms. lateral of the midline and is directed superiorly and posteriorly into the abscess cavity. A blunt needle such as a cerebral ventricle needle is used for the purpose. As much of the abscess contents as possible is aspirated and some of the substance examined immediately by microscope. The characteristic fluid obtained from an uncomplicated abscess is described as resembling anchovy or chocolate sauce in color. If there are many bacteria and pus cells present in the smear, these findings are indicative of secondary infection and may require open drainage. However, in such instances a course of sulfonamide and penicillin therapy should be given a thorough trial before open drainage is performed. Needless to say before each aspiration, the patient should receive emetine for a minimum of four days.

For abscesses located in the posterior portion of the liver, the exploring needle is inserted in the right lumbocostal angle and is directed superiorly and anteriorly to the abscess cavity.

For an abscess located near the dome of the liver, the needle is inserted through the ninth or tenth intercostal space in the anterior axillary line and directed superiorly.

The only dangers of aspiration are: 1. Spread of infection. 2. Hemorrhage. These dangers are minimized by careful technique. No irrigation of the abscess cavity is attempted nor is any antiseptic substance introduced into it.

In those abscesses complicated by pyogenic organisms which do not respond to sulfonamides and/or penicillin therapy, open drainage is essential. The chief cause of the high mortality formerly associated with open drainage was the infection introduced into the pleural or peritoneal cavity. To avoid this complication, open drainage is performed in such a way as to avoid these two serous cavities. The technique is the same as that employed for the extra-serous drainage of subphrenic or subhepatic abscesses. For such an abscess located anteriorly the Clairmont procedure is performed. This consists of a subcostal incision parallel to the costal margin cutting across the oblique muscles and the transversalis fascia and approaching the abscess extraperitoneally by mobilizing the parietal peritoneum from the lower surface of the diaphragm. For an abscess that is located posteriorly, the Ochsner approach utilizes this principle of avoiding the pleural and peritoneal cavities. The twelfth rib is resected subperiosteally. An incision is made through the bed of the twelfth rib at a level of the spine of the first lumbar vertebra. The retroperitoneal tissue is dissected bluntly until the peritoneum is encountered which is then separated from the under surface of the diaphragm until the region of the abscess in the posterior portion of the liver is reached. Ochsner and De Bakey<sup>4</sup> in recent articles have emphasized the great reduction in mortality accomplished by this extraserous method of drainage as compared with methods formerly in use in which so often the pleural cavity and/or the peritoneal cavity was infected, with fatal results.

Following the successful treatment of amebic hepatitis or amebic abscess by emetine and/or emetine and aspiration therapy, the intestinal amebiasis should be treated by one of the amebicides such as carbarsone, chiniofon, viform or diodoquin.

#### PROGNOSIS

According to Ochsner and De Bakey<sup>5</sup> the most important factors in prognosis are: "1. The multiplicity of lesions in the liver. 2. The presence or absence of complications. 3. The presence or absence of secondary infections. 4. The type of therapy employed."

These authors report a collected series of five thousand cases in which the mortality was 43.1 per cent in those treated with open drainage, and 5.6 per cent in those receiving closed drainage. In their series the mortality was 22.1 per cent for open drainage, and 3.6 per cent for closed drainage. These same authors in quoting a series of eighty-one cases show a mortality of 33.3 per cent for transpleural drainage, 30.4 per cent for transperitoneal drainage, 10.5 for incision and drainage where the abscess pointed superficially, and a mortality of 6.6 per cent where the drainage was extraserous, thus emphasizing all too well the much better result to be obtained when the peritoneal and pleural cavities are avoided.

Little need be said concerning the multiple pyogenic hepatic abscesses occurring as part of the process of septicopyemia or as a result of ascending pyelophlebitis. These are hopeless conditions and the only treatment of any value would be prophylactic. The occasional solitary pyogenic abscess should be treated in the same way as an infected amebic abscess and drained extraserously.

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#### PORTAL CIRRHOSIS\*

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CIRRHOSIS of the liver has presented many complex problems of clinical and pathological physiology for study recently. Because it was formerly considered a virtually hopeless condition, the standard therapeutic attitude in dealing with this disease was essentially one of defeatism. Only in recent times have investigators been able to show the enormous functional reserve of the liver and its phenomenal capacity for regeneration and repair. Furthermore studies on animals treated with hepatotoxic agents have demonstrated the possibility of recovery even after the clinical picture of human portal cirrhosis has been produced. Experimental studies also have demonstrated the relation of diet and nutrition to the structure and function of the liver.

#### THE NUTRITIONAL FACTOR IN CIRRHOSIS

To review the clinical and experimental evidence bearing on the point that cirrhosis of the liver is a deficiency

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disease would greatly exceed the scope of the paper and only a few of the more important contributions will be mentioned.

The relationship of alcoholism to cirrhosis is well known; yet cirrhosis develops in only a small percentage of cases of chronic alcoholism and the disease cannot be reproduced experimentally in dogs who are given alcohol continuously in large quantities. Connor<sup>6</sup> suggested years ago that an inadequate intake of food might explain the susceptibility of some human beings to liver damage by alcohol, a point on which all students of the subject now agree. Patek<sup>19,20</sup> and others, noting that alcoholic beriberi and pellagra resembled in all respects the endemic forms of these diseases, conceived the idea that the correlation between alcoholism and cirrhosis might likewise depend on nutritional deficiencies. There is now ample clinical evidence to support this view. An inquiry into the dietary habits of many chronic alcoholics with liver disease will reveal that their intake of food is deficient in many respects. It is not remarkable that such patients also may have a variety of associated vitamin deficiency states which may be due not only to poor diet but to failure of absorption, storage and intermediate metabolism of vitamins because of associated liver damage.

In certain parts of the world cirrhosis is endemic; this possibly is due to nutritional disturbances. Snapper,<sup>24</sup> in commenting on the great frequency of cirrhosis in North China, stated that malnutrition is certainly one of the principal factors in the development of the disease. Hardiker and Gopal Rao<sup>12</sup> recently have reported a high incidence of cirrhosis of the liver in southeastern India where rice is the principal ingredient of the diet and have commented on the fact that in parts of India where Jawar and wheat constitute the staple diet, liver disease is relatively rare. Among South African Negroes who subsist chiefly on a meager diet of corn and fermented cow's milk, the incidence of both deficiency disease and cirrhosis is high. Gilbert and Gillman<sup>9</sup> have noted this fact and have shown that cirrhosis developed in rats fed the natives' diet.

Experimental evidence supporting the deficiency theory of the etiology of cirrhosis is abundant. György and Goldblatt<sup>10,11</sup> noted that parenchymatous and fatty degeneration, necrosis and sometimes fibrosis developed in the livers of rats maintained on a diet deficient in the vitamin B complex. These changes were prevented by the addition of yeast or yeast extract to the diet. Rich and Hamilton<sup>23</sup> have shown that a diet adequate in respect to all its essential constituents and containing adequate amounts of thiamine chloride, nicotinic acid, riboflavin and vitamin B<sub>6</sub> was capable of producing marked hepatic cirrhosis in rabbits. Animals, fed exactly the same diet but with yeast substituted for the various individual components of the B complex, did not develop hepatic lesions. Various other workers have shown that riboflavin or thiamine deficiency alone will under certain circumstances produce fatty change in the liver. Hepatic functional disturbances also have been produced by somewhat similar types of experimentally deficient diets. Work along these lines is being continued and extended and all investigators now agree that an inadequate intake of protein and certain components of the B complex will produce liver damage or render the liver vulnerable to experimentally administered hepatotoxic agents (diachloro-ethane, dichloropropane, carbon tetrachloride, halowax and others).<sup>17</sup>

Recently attempts have been made to identify the component of B complex, deficiency of which is specifically responsible for the development of cirrhosis. Since fatty infiltration of the liver is among the earliest of pathologic changes in cirrhosis, it is natural that attention should have been paid to lipotropic substances

in this respect. Choline and also methionine have been shown to have a protective effect in cirrhosis induced in laboratory animals. Cystine has a similar effect and the combination of cystine plus choline appears to have extraordinary protective effects against hepatotoxins. Casein digests also have a considerable protective action under similar conditions possibly because of the combination of cystine and methionine which such digests contain. The clinical application of these observations gives promise of major improvements in the treatment of the disease.

#### THE RECOGNITION OF CIRRHOSIS

The matter of diagnosis obviously becomes more important with the advent of new therapeutic methods. The clinical picture of far advanced cirrhosis of the liver can be recognized by any medical student. However, in many early cases the disease may pass undetected for long periods and the diagnosis is often difficult.

The common signs and symptoms of cirrhosis are so well known that their enumeration is scarcely necessary. Periodic digestive upsets characterized by anorexia, nausea, vomiting and gaseous distention are among the most common initial complaints. When a patient complains of these, an inquiry should be made into his alcoholic and dietary habits, exposure to chemicals, previous episodes of jaundice, edema, hematemesis and finally into the possibility of exposure to schistosomiasis. Weakness and loss of weight appear relatively late in the course of the disease and may be accelerated prior to the appearance of ascites, which occurs in approximately two-thirds of all cases. The appearance of ascites may be preceded, followed by or associated with edema of the lower extremities and genitalia. Jaundice which is often of too slight degree to attract the patient's attention occurs at some time in perhaps four out of five cases. Hematemesis or other signs of a tendency to bleed, such as hematuria, also are common.

Other symptoms of the disease which are not so well known deserve more general recognition. Among these are bouts of abdominal pain which, because of their severity and the not infrequent association of jaundice, have been known to raise the suspicion of common duct stone. Irregular fever of low grade is also a fairly common early symptom; it appears to be associated with destruction of liver cells and not necessarily with a complicating infectious disease. Neurologic symptoms are likewise more common than is generally believed. These include a wide range of complaints from mild psychogenic disturbances to deep coma.

Among the less commonly recognized physical signs are three which merit attention. These are (1) loss or absence of pectoral hair in males, (2) a curious erythema of the palms, a finding which is common but which is not necessarily specific for cirrhosis and (3) spider hemangiomas over the distribution of the superior vena cava. These hemangiomas, which have been thought to be due to the failure of the liver to inactivate androgenic materials and 17-ketosteroids, are, for practical purposes diagnostic of cirrhosis and should be sought for in every case in which it is suspected. They vary in size but the definite pulsation in their central portion and the dilated web of capillaries which surround them make them easy to identify.

A number of special procedures are of assistance in proving the presence of cirrhosis. Among these by all odds the most valuable is peritoneoscopy. This procedure

is performed easily and may be done at the time of paracentesis. It carries a small surgical risk (most of the recorded catastrophes following it have been due to intraperitoneal bleeding). It has the great advantages of permitting direct visual inspection of the liver as well as the opportunity of removing a specimen for biopsy from a selected part. It also permits the exclusion of such commonly associated conditions as tuberculous peritonitis and primary hepatic malignancy.

Another method of obtaining specimens of the liver for biopsy should be mentioned. Needle biopsy through the thoracic or abdominal wall was first performed about fifty years ago; two Scandinavian investigators, Iversen and Roholm<sup>14</sup> later rediscovered the method and called it to physicians' attention. The development of the Vim-Silverman needle by Tripoli and Fader<sup>26</sup> in 1941 has greatly facilitated satisfactory liver biopsy by this method. The procedure is now in standard use in at least one university clinic<sup>13</sup> and will undoubtedly be used more widely in the future. The information obtained by histologic examination of liver tissue is invaluable and supersedes all other procedures in reaching a diagnosis.

Hematemesis occurs at one time or another in about half of all cases of portal cirrhosis. Its sources are almost invariably the dilated esophageal veins which form as a result of portal venous obstruction of long standing. Their presence should be sought for in every known or suspected case of cirrhosis. By the use of a thick barium mixture, these dilated vessels can be demonstrated roentgenologically in a majority of cases in which they are present. Their direct visualization can be accomplished through the use of the esophagoscope. Demonstration of these dilated veins is practically diagnostic of cirrhosis even if most other symptoms and signs are lacking.

The roentgen visualization of the general structure of the liver by means of thorium dioxide (thorotrast) is invaluable in certain cases, particularly when it is essential to exclude the possibility of metastatic lesions. Metastatic lesions are visualized as negative shadows, as are also gummas. Cirrhosis gives a definite roentgenologic picture; the liver has a finely mottled appearance suggestive of ground glass. It was formerly believed that visualization with thorotrast carried some risk because of the radioactive character of the material used. However, the experience of many workers has shown that the radioactive effect of thorotrast is not clinically significant in the type of case in which it is generally used.

*Liver function test.*—These tests are useful for demonstrating injury to the parenchyma of the liver but they do not necessarily establish either the type or degree of damage present. After more than twenty years of search for a single test which would give the desired information, most investigators have reached the conclusion that it is wise to depend on two or three general tests carefully performed. The three most often recommended which have satisfied critical investigators are (1) the cephalin-cholesterol flocculation test, (2) the hippuric acid test for liver function, which may be determined by either the oral or intravenous administration of sodium benzoate and (3) one of the various modifications of the bromsulphalein test. The first mentioned test requires considerable care in its performance and difficulties may arise because of technical problems in connection with the preparation of a uniform cephalin antigen of a proper degree of sensitivity. If the test is used, controls must be employed. False positive results have been observed in the presence of various diseases not involving the liver, among which may be mentioned allergic or puerperal states.<sup>7,16</sup> The hippuric acid

test is of limited value in the presence of renal insufficiency but when this condition can be excluded, it is satisfactory and gives a reasonably good idea of the total mass of functioning hepatic cells. Most recent reports on this test appear to indicate that the intravenous method of administration is preferable to the oral, and, in fact, the test is rated as about twice as sensitive when the intravenous method is employed. The bromsulphalein test, using a dose of 5.0 mg. per kilogram of body weight, is still one of the most satisfactory tests of liver function. Readings at the end of forty-five and sixty minutes are recommended by Mateer and co-workers.<sup>16</sup> The test is of no value in the presence of clinically recognizable jaundice but if this limitation is kept in mind, it is one of the most useful in the early diagnosis of cirrhosis.

For maximal accuracy in liver function studies, the "profile" method advocated by Watson<sup>28</sup> is recommended. This method employs practically all the known standard tests of liver function; specific groups of tests are designed for both jaundiced and nonjaundiced patients and there are supplementary tests which are applicable to both types of patients. Because of expense, time and technical difficulties, this method of study doubtless will have to be confined to clinics with special facilities. As Watson and his collaborators<sup>13</sup> pointed out in their most recent report, certain types of cirrhosis or other hepatic diseases show a fairly characteristic "profile" on the chart giving composite results of the tests of liver function. They also pointed out wisely that even these detailed studies of liver function will never do more than supplement the history and physical examination in a given case, a statement which generally applies to all methods of functional study of the liver.

#### PROGNOSIS

Cirrhosis even when detected at a supposedly early date is usually an old and well-advanced disease. It is unfortunately only rarely suspected before the onset of jaundice, ascites or hemorrhage. When one or more of these symptoms have made their appearance, the prognosis is grave and approximately half of all such patients die within a year. Gross hemorrhage, in particular, indicates an unfavorable course.<sup>22</sup> In one recently reported series,<sup>20</sup> 40 per cent of patients died within one month of the initial hematemesis. However, if a patient survives such a catastrophe for a year, his chances for survival seem to improve somewhat.

Much the same statement may be made in regard to ascites. In two large series of cases studied at the Mayo Clinic<sup>5,8</sup> the average duration of life after the appearance of ascites was about fourteen months but two-thirds of the patients were dead at the end of nine months.

The history or physical findings usually present little to indicate what patients may be expected to survive this critical first year. Persistent fever and the early development of neurologic symptoms are of ominous import. The same may be said of deepening jaundice and increasingly rapid accumulation of ascitic fluid. Laboratory methods are, at best, of limited value to the physician in determining the prognosis. Increasing anemia and a falling level for total protein and serum albumin are indicative of an unfavorable outcome. The reverse of this statement is partially true and improvement in the erythrocyte count and level of plasma proteins under treatment is most encouraging. A low level for prothrombin is a fairly common finding in cirrhosis and is not necessarily of great prognostic value. However, the response to vitamin K in such cases is definitely informative. If a fair amount of liver parenchyma remains, the response to administration of the synthetic vitamin may not fall far short of that seen in patients



with obstructive jaundice. Complete failure of response to vitamin K therapy, however, is indicative of extensive damage.<sup>15</sup> High levels for coproporphyrin in urine are also of serious prognostic significance. No clinical findings or combination of functional tests is as important in determining the long range outlook, however, as is the patient's immediate response to treatment.

#### TREATMENT

Within the past few years there has been a radical change in the therapeutic approach and a modern program of treatment is now based almost entirely on the conception that cirrhosis of the liver is a deficiency disease.

On the basis of the studies mentioned earlier on this point and numerous clinical observations, Patek<sup>19</sup> in 1936 began the treatment of a group of patients who had alcoholic cirrhosis with a highly nutritious diet and large amounts of vitamin B complex. The results which were first reported about eight years ago were most encouraging and have since been confirmed by investigators in many parts of the country. Details of the diets now in use have been modified according to the preference of the investigator. The original Patek diet contained carbohydrate 365 gm., protein 139 gm. and fat 175 gm.; it was made up largely of meat, milk, eggs, fruit and green vegetables and was heavily supplemented with brewer's yeast, thiamine chloride and injectable liver extract. At the Mayo Clinic<sup>8</sup> a somewhat similar diet containing approximately 500 gm. of carbohydrate, 110 gm. of protein and 60 gm. of fat has been employed. The protein in this diet was derived partly from vegetable and dairy products, chiefly because of an earlier observation that animals with experimentally produced hepatic injury were made worse by the administration of meat and meat extracts. The lower intake of fat in this diet is justified on the grounds that even small increments of fat in the diet make the liver definitely more vulnerable to such toxic substances as carbon tetrachloride (Bollman).<sup>3</sup> Maximal quantities of both water and fat soluble vitamins were given. Wade<sup>27</sup> has advocated a somewhat similar dietetic program, while Barker<sup>1</sup> has adhered more closely to the original Patek regimen. The ultimate results of treatment reported by workers just mentioned are essentially the same so it seems fair to assume that the essentials of the program are an adequate and palatable diet, rich in carbohydrate and protein and heavily supplemented by natural sources of the vitamin B complex, notably yeast and liver.

Various supplementary measures deserve brief mention. A clinical study of choline and methionine is now being made but it appears to be too early to report any definite results. Patek<sup>18</sup> mentioned one patient whose condition had been resistant to the usual dietetic treatment and who improved greatly after the administration of choline hydrochloride, 4 gm., daily. English investigators<sup>2,21</sup> have reported encouraging results with methionine. Casein digests have been employed both experimentally and clinically with results sufficiently good to warrant their continued use. Further studies along these lines with especial reference to lipotropic substances promise to add greatly to the therapeutic effectiveness of the dietetic program, particularly in the earlier stages of the disease.

*Of special features of the disease.*—Most clinicians who have had wide experience with cirrhosis are now inclined to treat the ascites by means of paracentesis and to avoid use of purgatives and diuretics. The latter may be used judiciously in selected cases, the time honored combination of acid-producing salts and organic mercurial diuretics being still in favor. Attempts to relieve ascites by correcting the hypoproteinemia so commonly associated with advanced disease of the liver have been disappointing. The use of plasma, serum albumin and even rein-

jected ascitic fluid have usually failed to produce the desired diuretic effect. In this connection it may be pointed out that some factors other than osmotic and portal pressures may be concerned in the transudation of fluids in this disease. It has been suggested too that the diseased liver may produce specific antidiuretic substances.

The anemia of liver disease is especially refractory to treatment. It may respond somewhat to the injectable forms of liver extract and to iron, but in general it is not much altered until the liver itself regenerates. For this reason, transfusion of blood must be relied on to maintain the patient's hemoglobin.

Coma and other neurologic disturbances associated with hepatic insufficiency may be of nutritional origin and related to two other deficiency states, the encephalopathic syndrome associated with chronic alcoholism and the psychosis of the pellagrin. It is believed that all three of these conditions may be due to a breakdown of enzyme systems associated with carbohydrate metabolism. As is well known, these enzymes derive certain portions of their molecular structure from nicotinic acid and thiamine. In the treatment of hepatic coma, it is logical, therefore, to administer glucose with sufficient quantities of nicotinic acid and thiamine to insure complete utilization. This form of treatment has been productive of good results in a few cases.<sup>25</sup>

Hemorrhage in cirrhosis requires special consideration. As has been stated previously, the common source of bleeding is from a ruptured esophageal varix. A dangerous hemorrhagic state develops in a small number of cases because of prothrombin deficiency. Neither condition is as yet completely amenable to treatment. Splenectomy, omentopexy and ligation of the coronary vein of the stomach have all been employed with some success in dealing with esophageal varices. Recently the direct injection of these vessels with sclerosing solutions through the esophagoscope has been employed with satisfaction both in this country and abroad,<sup>7</sup> and it seems likely that some treatment of this type may eventually provide the answer to the problem of esophageal varix provided that the fundamental process in the liver can be controlled.

The severely diseased liver is incapable of utilizing vitamin K to form prothrombin and, therefore, the treatment of hemorrhagic states in cirrhosis is almost totally ineffective except in occasional cases. With improvement in the general state of the liver, the opportunities for successful therapy with naphthoquinone derivatives may increase.

#### RESULTS

The results of treatment have by far exceeded expectations and patients with proved cirrhosis now have carried on successfully for as long as eight years. The mortality rate from the disease during the first year after the appearance of ascites continues to be high, but it is still vastly less in the treated than in control groups. Patek reported that 45 per cent of his patients have survived for two years,<sup>20</sup> and Fleming and I<sup>8</sup> have reported a substantial group of arrested cases with a survival period of more than two years. A few cases have been recorded in which loss of ascites, edema and jaundice has occurred several times as a result of dietary therapy. As Patek<sup>18</sup> has noted, these successive responses in the same patient "give added significance and dignity to the cause of dietetic therapy." Because of the fact that the disease affects principally persons in the older age groups, and also because of the unpredictable behavior of the alcoholics who make up a large proportion of the group under consideration, the long range prognosis is not particularly good. It is an extremely difficult matter to make many of these patients follow the prescribed diet and the sicker patients require the best of nursing and dietetic care. With patience and persistence, however, much may

be accomplished. It is obvious that the disease is as a rule detected only in its latest stages and that much earlier diagnosis will be required if the current figures of mortality and morbidity are to be greatly improved.<sup>4</sup> In the earlier stages of the disease when the liver is presumably affected chiefly by fatty degeneration and the portal circulation is not greatly restricted, the results of therapy should be excellent.

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## THE STATUS OF THE LIVER AND ITS IMPORTANCE TO THE SURGEON\*

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THE status of the liver and its importance to the surgeon constitutes an exhaustive background for discussion. The functionally and histologically disturbed liver is a sensitive criterion of the degree of damage resulting from many extra hepatic pathological states. Many diseases and many agents result in degenerative changes in the liver. With progression of the disease, the hepatitis is also insidiously progressive and results finally in some degree of irrevocable fibrosis.

The liver has remarkable reparative capacities. A single major injury or repeated minor injuries may result in no permanent damage because of this extraordinary power of regeneration. Continuation of these injuries, however, will eventuate in a chronic generalized hepatitis because of a failure of these regenerative processes and a replacement of the functioning parenchyma with connective tissue.

A comparatively small remnant of normally functioning liver parenchyma will compensate for the whole in such a degree that there is no depression in the hepatic sufficiency tests nor is there symptomatic clinical evidence of disturbed function. Practically, then, it becomes incumbent upon the surgeon to recognize that liver damage is almost invariably sequential to certain surgical diseases and that restoration of hepatic function should be attempted before the elective surgery is undertaken.

#### TYPES OF LIVER DISEASE

The most common diseases, either actually or potentially surgical, that eventuate in some degree of hepatic parenchymatous destruction are:

- (1) The infections.
- (2) The benign peptic ulcer.
- (3) Extra-hepatic biliary disease.
- (4) Thyrotoxaemia.
- (5) Gastro-intestinal malignancies.

*Infections.*—Secondary destruction of liver tissue by infection is not limited to primary peritoneal involvement by the infecting agent. The acute appendix typifies the primary involvement with secondary damage to liver parenchyma through the portal route. Even death may occur without evidences of a spreading peritonitis but with demonstrable depression of hepatic physiology and with gross and histological liver damage.

The acute surgical abdomen may be complicated by concomitant but unrelated diseases that are associated with hepatic involvement. Medical officers with troops are concerned primarily with acute phases of such diseases. The civilian surgeon will be particularly concerned later upon discharge of these service men with the more chronic phases with progressive liver deterioration.<sup>1</sup> These diseases include malaria, sporadic and epidemic hepatitis, leptospiral jaundice or Weils disease, schistosomiasis and amoebic hepatitis.

*Duodenitis with Peptic Ulcer.*—Ascending infection from the duodenum through the Ampulla of Vater characterizes the duodenitis associated with peptic ulcer. Here, as in the portal route of conveyance of the infection, parenchymatous destruction is evident and pylephlebitis with concomitant hepatic miliary abscesses is absent.

*Extra-hepatic Biliary Disease.*—Diseases of the extra hepatic biliary tract and particularly gallbladder disease

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originally stimulated the study of liver sufficiency as it was related to surgical practice. Gallbladder disease is essentially a chronic disease.<sup>2</sup> Acute cholecystitis does occur, but it is usually an acute exacerbation in a chronically diseased gallbladder. In the perennial controversy over the respective merits of the delayed versus the immediate surgical treatment of acute cholecystitis, neither protagonist adequately considers the effect of depressed liver function on the mortality and morbidity rate in individual cases. In the absence of the accepted criteria for emergent surgical intervention, hepatic function, as estimated clinically and by laboratory data, dictates more reliably the time of surgical intervention.

*Thyrotoxaemia.*—In thyrotoxicosis, jaundice is clinically evident in about 5 per cent of patients and particularly in the preoperative crisis. Clinical jaundice is evidence of some degree of hepatitis even though our present laboratory tests fail to measure a depression in function. The most progressively restricted hepatic function in thyrotoxicosis is its ability to metabolize and store glycogen. The histological changes in the liver are variously described and are not consistently identical. Three characteristic changes have been described as common to all patients.<sup>3</sup>

1. Diffuse deposition of fat in the parenchymal cells.
2. Central necrosis of the hepatic cords.
3. Periportal connective tissue proliferation.

Since no proof is available that thyroxine is toxic to the individual cell, the hepatic damage is best explained on the basis of chronic anoxia in a liver already showing increased oxygen consumption and glycogen depletion.<sup>4</sup>

The majority of thyrotoxic patients undoubtedly have only minimal hepatic damage. In that recognizable minority with clinical jaundice or other evidences of liver depression, preoperative preparation and postoperative convalescence are more usually complicated and prolonged.

*Gastro-intestinal Malignancies.*—Gastro-intestinal cancer results in a high incidence of fatty infiltration and probably glycogen depletion in the liver.<sup>5</sup> Demonstration of the diminished hepatic function by our present methods is usual in gastro-intestinal malignancy before liver metastasis occurs. Surgical procedures are tedious and prolonged and contribute towards further postoperative depression. These recent studies advance the possibility that "altered hepatic chemical constitution" complicates the risk in gastro-intestinal cancer and that proper preoperative preparation will change hepatic chemistry and increase resistance to hepatotoxins.

In evaluating the liver function tests it must be recognized that any conclusions are altogether relative. A high degree of hepatitis with dysfunction may be present without laboratory evidence in any of the tests. The latent functional activity of liver parenchyma will remarkably compensate for a major loss and there will be no clinical or other evidence of destruction.

The best estimate of functional capacity is obtained from a correlation of laboratory data and clinical findings.

Chemical tests attempt to determine departures from normal in liver metabolism, including bile, protein, carbohydrate, fat and lipid metabolism and the detoxifying and excretory functions of the liver. In recent reports of experimental study,<sup>6</sup> it was concluded that the brom-sulfalein test was the most sensitive in detecting damage while a rise in the serum phosphate value was the second most reliable indication. The prothrombin time was less sensitive but demonstrated damage before the intravenous galactose tolerance test. These findings have not been corroborated clinically.

The hypoproteinemia of hepatitis seems to be selective. As chronicity develops, the serum albumen level becomes more depressed.

#### COMMENT

The value of the individual liver function test is easily over estimated. However, used in association, more will become depressed as intrinsic damage progresses.

Clinically, in the absence of extra hepatic biliary obstruction, jaundice is evidence of some degree of degeneration and with further deterioration, renal changes become apparent. Latent hepatic disease, with the contributing and evident extra hepatic lesion, probably accounts for the hepatorenal syndrome and the so called liver death.<sup>7,8</sup> Exploratory evidence of the degree of liver damage is not always reliable in the absence of biopsy.

The details of treatment in depressed hepatic function are not within the province of this discussion. It has long been known that a high fat diet is contra-indicated in the presence of a damaged liver. It has been known, further, that high carbohydrate intake is salutary. These clinical observations have been correlated with the results of experimental investigation. A high concentration of lipid in the liver is pathological, an adequate quantity of stored glycogen is protective but only in the absence of an abnormal content of liver fat.<sup>5</sup>

A high protein intake is clinically beneficial in hepatitis. Recent studies of liver biopsies in surgical patients have furnished a background for this conclusion.<sup>9</sup> A diet high in protein diminishes the deposition of fat in the parenchymal cells and minimizes hepatic destruction. Experimental studies have demonstrated that certain constituents of protein are more effective than the whole protein. Among these components, choline has been used more extensively both experimentally and clinically and there seems to be good reason for its continued use in diseases associated with liver destruction.<sup>10</sup> There are now commercially available protein hydrolysate products. Our clinical experience has been with Amigen. Amigen is a pancreatic hydrolysate of casein and given slowly in dextrose solution, untoward reactions will be minimized and it is well tolerated.

In addition to high carbohydrate, high protein and low fat intake, preparation must include supplementary vitamins, particularly Vitamin B, and adequate Vitamin K administration.

#### SUMMARY

Hepatitis with parenchymatous damage is a complicating sequence of many extra hepatic surgical diseases. Latent functional hepatic activity will remarkably compensate for even a major injury and there will be no clinical or other evidences of destruction. Even in the absence of such evidences, some degree of liver damage must be assumed and appropriately treated.

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## THE USE OF PRODUCTS OF FIBRINOGEN AND THROMBIN IN OTOLARYNGOLOGY\*

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PURIFIED fractions of human fibrinogen and thrombin have been obtained in the course of large scale fractionation of human blood plasma.<sup>1</sup> These proteins in solution, as well as several materials prepared from them, have been employed in surgery. The products, differing greatly in physical properties and the uses to which they are adapted, possess characteristics which are constant and entirely dependent upon the conditions of manufacture.<sup>2</sup>

Ingraham and Bailey<sup>3,7</sup> have described the use of fibrin foam and a solution of thrombin as an absorbable hemostatic agent, and the use of fibrin film as a dural substitute or as a means of preventing meningeocerebral adhesions.<sup>4</sup> They have also called attention to the great potential usefulness of an admixture in situ of solutions of fibrinogen and thrombin in certain special localities where the resulting clot provides a physiologic adhesive material.<sup>3</sup>

For use in surgery, fibrinogen and thrombin are obtainable in a commercial product supplied in three bottles. One bottle contains sterile fibrin foam in the form of dry, brittle, firm blocks with a honeycomb structure composed of fibrin with numerous air spaces of varying size. A second bottle contains dried human thrombin while the third bottle contains 30 c.c. of sterile isotonic sodium chloride solution.

Rapid solution takes place when the saline solution is added to the dry thrombin. Pieces of fibrin foam, placed in the thrombin solution, shrink, become rubbery and are immediately available for hemostasis. The proportion of thrombin solution used determines to some extent the consistency of the moistened fibrin foam.

Ordinarily, the dry fibrin foam is divided into pieces of appropriate size and then placed in the thrombin solution but the moistened blocks may also be cut as required with a scissors or scalpel. The rubbery consistency enables the fragments to be molded to conform with the contours of the sites to which they are to be applied. Pieces of fibrin foam adhere to each other but do not fuse. Excess moisture may be removed by sponging and suction with a Frazier tip without dislodging the foam or altering the form to which it has been shaped.

It should be emphasized that while bleeding from numerous small vessels may be controlled by applying thin slices of fibrin foam, arterial hemorrhage requires the usual orthodox surgical methods for its control.

### FIBRIN FOAM AND THROMBIN AS HEMOSTATIC AGENTS

As a hemostatic agent, fibrin foam and thrombin possess numerous advantages.<sup>3,4,7</sup> Since they are prepared from human fibrinogen and thrombin, they are composed entirely of proteins native to human plasma. They rapidly control bleeding from oozing surfaces and veins. Left in place after an operation, they are absorbed with minimal tissue reaction and the location of the fibrin foam can no longer be detected in tissue sections taken one month after operation. Recurrence of hemorrhage is

minimized because the fibrin foam remains in place after hemostasis is obtained. The rapid and complete hemostasis appreciably reduces the operating time. Even when sulfonamides or penicillin are used with the material tissue reactions are unaltered. Fibrin foam with thrombin controls bleeding from tooth sockets of patients with hemophilia and has effected prompt and complete hemostasis in hemophiliacs with lacerations of the tongue and lower extremity.<sup>3</sup>

### USEFULNESS IN OTOLARYNGOLOGICAL SURGERY

The clinical use of fibrin foam and thrombin has demonstrated a wide range of usefulness in otolaryngological surgery. In *tonsil surgery* they seem destined to play a minor rôle. There has been considerable hesitancy in using fibrin foam in the fossae because of the possibility of aspiration of dislodged fragments.<sup>3</sup> Aside from obstruction of bronchi, the absence of reaction to these materials elsewhere in the body would indicate that their mere presence in the lower respiratory tract would be innocuous. The usual surgical methods of controlling arterial bleeding must be used but control of general oozing can be obtained by applying shavings of fibrin foam. Larger pieces of fibrin foam may be introduced into a fossa and secured by suturing the pillars. Unless tension is estimated accurately, the sutures will cut through the fibrin foam and dislodge it. Except in hemophiliacs, the use of fibrin foam and thrombin in tonsillectomy is of limited value.

Although pressure over a bleeding point in *Kiesselbach's area* controls the bleeding, recurrence usually follows removal of pressure. For this reason cauterizing agents such as trichloroacetic acid, chromic acid, silver nitrate or the electrocautery must be used to secure hemostasis. These produce local tissue destruction and thus delay healing. When fibrin foam and thrombin are held over the bleeding point and pressure is maintained for a few moments with a cotton wound applicator, the fibrin foam remains in position when the pressure is released and continues to provide hemostasis. No tissue damage is produced to delay healing.

An entire nostril or both nostrils may be packed with fibrin foam when *epistaxis* occurs from an unidentifiable area. The rubbery consistency of the material enables it to conform to the contours of the intranasal structures. The inability of fibrin foam and thrombin to provide hemostasis in arterial bleeding was demonstrated in one patient in whom the bleeding point could not be located. Both nostrils were packed with fibrin foam and thrombin without controlling the hemorrhage. Even after introducing a postnasal tampon and again packing both nostrils with the moistened fibrin foam, the bleeding continued unabated. Hemostasis was finally obtained by packing both nostrils with gauze saturated with thrombin solution, after a postnasal tampon had been introduced.

By making a small hole in blocks of fibrin foam with thrombin, the thread of a postnasal tampon can be passed through one or more blocks. When the postnasal tampon is drawn into position, the fibrin foam is carried into the posterior nares to exert its hemostatic action.

A wafer of fibrin foam and thrombin placed over the site of the incision at the conclusion of a *submucous resection operation* materially reduces postoperative oozing and prevents gaping of the wound margins.\*

During the *Caldwell-Luc operations*, the antrum may be entirely filled with fibrin foam and thrombin just prior to suturing the gingivolabial incision. Additional material may be placed about the nasointral window within the nostril. Postoperative oozing is thus decreased and the removal of packing with its discomfort and secondary

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hemorrhage eliminated. Sulfathiazole, sulfanilamide or penicillin have been added to the fibrin foam thus introduced without in any way affecting the hemostatic action. Roentgenograms of the operated antra after lipiodol injection have shown that the fibrin foam clot remains largely unchanged for a period of a week or ten days and then undergoes lysis. There appears to be some organization of the clot immediately adjacent to the bony walls. The material is not as rapidly absorbed as in more vascular areas but in the presence of infection rapid lysis occurs and eliminates obstruction to drainage by way of the nasosinusal window.

Following *intranasal ethmoidectomy*, the application of fibrin foam to the operated area controls bleeding not of arterial origin. Much of the customary oozing may be controlled. In *external sinus surgery* the judicious use of fibrin foam reduces dead space and materially improves the cosmetic result.

Capillary and venous oozing from the soft tissues during *mastoidectomy* which continues after ligation of bleeding points is promptly controlled by the application of thin shavings of fibrin foam and thrombin. The positive hemostasis and the provision of a dry field materially reduces the operating time. Particles of the same material serve as a substitute for bone wax providing that they remain in position when applied with pressure.

In two patients, fibrin foam and thrombin introduced into the opened lateral sinus after the removal of the primary clot, reduced the amount of packing required to maintain hemostasis and there was less fear of hemorrhage when the gauze packing was removed.

Solutions of fibrinogen and thrombin, rather than the products manufactured from them, have been used in *skin grafting*.<sup>3,5</sup> These solutions are effective in the control of *nasal hemorrhages* in patients with leukemia and other blood dyscrasias. They are usually painted or sprayed on the mucous surfaces or used to impregnate gauze packing.<sup>3</sup> They are preferable in tonsillectomy because they obviate the aspiration of solid material but are rarely necessary to reinforce the customary methods of hemostasis except in patients with blood dyscrasias. When sprayed on bone after the removal of the lining mucosa of the sinuses, they provide a dry field for further exploration.

#### FIBRIN FILM

*Fibrin film* is a plasma plastic with characteristics recommending its use in many otolaryngological procedures. It is a strong, translucent, pliable, elastic material prepared from solutions of fibrinogen and thrombin under conditions differing from those employed in producing fibrin foam.<sup>6</sup> It has been used extensively in the preparation of artificial ear drums. When applied to the tympanic membrane the film adheres readily and in the absence of infection in the middle ear will remain attached for long intervals. Catheterization and inflation of the eustachian tube dislodges the film and enables the margins of the perforation to be freshened before a new film is applied.

Unintentional tears in the mucous membrane during the course of a submucous resection operation can be covered by a disc of fibrin film which adheres promptly, exerts some hemostasis and approximates the cut edges. With reasonable care it is not detached in the course of subsequent packing.

Fibrin film offers a new medium in the repair of septal perforations. It may be introduced between the undermined tissues about the perforation and additional sheets of film applied on either side of the defect. In the case of large perforations it is difficult to apply and under-

goes lysis before repair is complete. In these it may be necessary to use a sheet of mucous membrane obtained from an inferior turbinate. The fibrin film is then used to provide a protective covering on both sides of the septum. The process may require repetition and will fail in very large perforations or those due to vascular or systemic disease.

*Fibrinogen plastic*<sup>6</sup> is another plasma product which deserves further clinical application. It is adaptable in shape and consistency to meet the requirements of a supporting or splinting material and is completely absorbed without residual cellular alterations. In the management of some fractures of the nasal bones, sinus walls and in some plastic procedures, fibrinogen plastic will eliminate the necessity of external fixation.

#### CONCLUSIONS

1. Fibrin foam with thrombin is a valuable hemostatic agent in otolaryngological surgery.
2. Solutions of fibrinogen and of thrombin are useful in areas where the presence of fibrin foam raises the possibility of aspiration.
3. Fibrin film is adaptable to the manufacture of artificial ear drums and to the plastic repair of septal perforations.

Santa Margarita Ranch Hospital.

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*Parkinson's Disease*.—A permanent place in medical history has been assured James Parkinson for his "Essay on the Shaking Palsy," written in 1817. It was he, too, who gave the first report in English on a case of appendicitis, this being also the first in which the cause of death was attributed to perforation. Aside from his medical interests, he was a writer of political and controversial pamphlets and, as an able geologist and palaeontologist, he contributed important works on fossil remains.—*Warner's Calendar of Medical History*.

Peace, commerce, and honest friendship with all nations,—entangling alliances with none.

—Thomas Jefferson, *First Inaugural Address*, 4 March, 1801.

# CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

## CALIFORNIA MEDICAL ASSOCIATION†

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SAM J. McCLENDON, M.D.....President-Elect  
E. VINCENT ASKEY, M.D.....Speaker  
LEWIS A. ALESEN, M.D.....Vice-Speaker  
PHILIP K. GILMAN, M.D.....Council Chairman  
JOHN W. CLINE, M.D., Chairman, Executive Committee  
GEORGE H. KRESS, M.D., Secretary-Treasurer and Editor  
JOHN HUNTON.....Executive Secretary

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## OFFICIAL NOTICES

### EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

#### *Minutes of the One Hundred Ninety-third (193d) Meeting of the Executive Committee of the California Medical Association*

The one hundred ninety-third (193d) meeting of the C.M.A. Executive Committee is recorded as a vote-by-mail meeting, the decisions having been reached by telephone intercommunication on June 8, 1945, with subsequent ratification of minutes by mail by Doctors Gilman, McClendon, Askey and Cline.

#### 1. Roll Call of Voting Members:

President and Council Chairman Philip K. Gilman; President-Elect Sam J. McClendon, Speaker E. Vincent Askey, John W. Cline, Chairman of the Auditing Committee.

#### 2. Concerning Senate Bill 1306:

Dr. John W. Cline, after conference with President Gilman authorized Dr. Gilman to telephone to President-Elect Sam J. McClendon and Speaker E. Vincent Askey, relative to request submitted by the Chairman of the C.M.A. Committee on Public Policy and Legislation, Dr. Dwight H. Murray of Napa, concerning Senate Bill 1306. S.B. 1306, introduced on June 2, 1945, by State Senator Arthur H. Breed of Oakland, contained provisions that could make for complications in the development of medical service plans in California.

After exchange of opinion the four members of the C.M.A. Executive Committee unanimously agreed that the C.M.A. Committee on Public Policy and Legislation should be instructed to oppose S.B. 1306, and President Philip K. Gilman and Messrs. John Hunton and Howard Hassard were delegated to oppose S.B. 1306 at the Senate Committee hearing on Monday, June 11, 1945.

JOHN W. CLINE, M.D.,  
Chairman, C.M.A. Executive Committee,  
GEORGE H. KRESS, M.D.,  
Secretary, C.M.A. Executive Committee.

#### *Minutes of the One Hundred Ninety-fourth (194th) Meeting of the Executive Committee of the California Medical Association*

The 194th meeting of the C.M.A. Executive Committee is recorded as a vote-by-mail meeting, decisions having been reached by telephone intercommunication on Tuesday, June 24, 1945, with subsequent approval of minutes by mail vote of Doctors Gilman, McClendon, Askey and Cline.

#### 1. Roll Call of Voting Members:

Philip K. Gilman, President and Chairman of the Council; Sam J. McClendon, President-Elect; E. Vincent Askey, Speaker, and John W. Cline, Chairman.

#### 2. Proposal to Establish a Nevada Physicians' Service:

The conference was held to present a report upon a meeting held with members of the Nevada State Medical Association. A plan was discussed whereby a Nevada

† For complete roster of officers, see advertising pages 2, 4, and 6.



Physicians' Service would be established in the State of Nevada, the same to begin its work as a regional group to be administered (temporarily as such), through California Physicians' Service.

### 3. Action Taken:

In order to make possible the institution of the plan whereby another voluntary prepayment group would come into operation through cooperation with its constituent State medical association, at the request of California Physicians' Service, the Executive Committee, voted that the California Medical Association loan to California Physicians' Service the sum of \$300.00 per month, for a period not longer than twelve (12) months (if necessary), to place Nevada Physicians' Service on a working foundation.

Further, the said loan from the C.M.A. to C.P.S. to be repaid by California Physicians' Service within a period of some thirty-six (36) months after the completion of the aforesaid loan.

JOHN W. CLINE, M.D.,  
*Chairman, C.M.A. Executive Committee,*  
GEORGE H. KRESS, M.D.,  
*Secretary, C.M.A. Executive Committee.*

### Proposed Amendment to C.M.A. Constitution Re: Ex-officio Members of Council

*For action taken on this resolution, see below.*

*Be It Resolved,* That the first paragraph of Section 1, Article VII, of the Constitution of the California Medical Association be amended to read:

"The Council shall consist of the Councilors, and ex-officio: The President, the President-elect, the Speaker and Vice-Speaker of the House of Delegates, each with all the rights of a Councilor."

*Resolved,* That the first paragraph of Section 4, Article X of the Constitution of the California Medical Association be amended to read:

"The President, President-elect, the Speaker and Vice-Speaker of the House of Delegates shall be ex-officio members of the Council with all the rights of Councilors."

SPEAKER ASKEY: This is an Amendment to the Constitution and By-Laws and must lie on the table for one year and must be published twice during the year in the *Official Journal*. It is so referred to the Association Secretary to be laid on the table and published as required by the By-Laws.

(For reference in minutes of House of Delegates, see JUNE CALIFORNIA AND WESTERN MEDICINE, page 327.)

## COUNTY SOCIETIES†

### CHANGES IN MEMBERSHIP

#### New Members (16)

##### Alameda County (1)

Siebert, Alfred A., *Oakland*

##### Contra Costa County (2)

Dunphy, John, *Richmond*

Loewenstein, Edith, *Pittsburg*

##### Fresno County (3)

Freeto, F. R., *Fresno*

Nelson, George A., *Fresno*

Tostenson, Norman E., *Fresno*

##### Humboldt County (1)

Reicher, Jacob, *Eureka*

#### Sacramento County (2)

Carter, Kenneth L., *Sacramento*

Kassis, John, *Sacramento*

#### San Diego County (3)

Peters, Lindsay, *San Diego*

Sargent, Willard Snow, *San Diego*

Shea, Paul A., *San Diego*

#### Santa Clara County (3)

Ahnlund, Nels W., *San Jose*

Bellinger, S. B., *Agnew*

Cleveland, Luella S., *San Jose*

#### Tulare County (1)

Brady, R. F., *Visalia*

## In Memoriam

**Brown, Beaumont.** Died at Sacramento, July 2, 1945, age 68. Graduate of the College of Physicians and Surgeons of San Francisco, 1904. Licensed in California in 1924. Doctor Brown was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.



**Cochran, George Vrooman.** Died at Oakland, July 2, 1945, age 48. Graduate of the University of California Medical School, Berkeley-San Francisco, 1931. Licensed in California in 1931. Doctor Cochran was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



**Craig, Stephen Adelbert.** Died at Ontario, June 26, 1945, age 52. Graduate of the College of Physicians and Surgeons, Los Angeles, 1919. Licensed in California in 1920. Doctor Craig was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



**Fesca, Helmut William.** (First Lieutenant, United States Army.) Killed in action in Germany, July 27, 1944, age 27. Graduate of the University of California Medical School, Berkeley-San Francisco, 1943. Licensed in California in 1943. Doctor Fesca was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



**Green, Martin Icove.** Died at San Francisco, June 30, 1945, age 46. Graduate of the College of Physicians and Surgeons of San Francisco, 1921. Licensed in California in 1921. Doctor Green was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



**Inman, Jesse Headen.** Died at Bakersfield, July 15, 1945, age 44. Graduate of the University of California Medical School, Berkeley-San Francisco, 1929. Licensed in California in 1929. Doctor Inman was a member of the Kern County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

† For roster of officers of component county medical societies, see page 4 in front advertising section.

**Krout, Boyd Merrill.** Died at Stockton, May 4, 1945, age 60. Graduate of Harvard Medical School, Boston, Massachusetts, 1913. Licensed in California in 1919. Doctor Krout was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



**Phillips, Charles Eaton.** Died at Los Angeles, June 15, 1945, age 65. Graduate of the University of Illinois College of Medicine, Chicago, 1903. Licensed in California in 1912. Doctor Phillips was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



**Strong, Kenneth Clark.** Died at Inglewood, July 3, 1945, age 42. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1932. Licensed in California in 1932. Doctor Strong was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



**Tully, John James.** Died at Stockton, June 4, 1945, age 83. Graduate of the Cooper Medical College, San Francisco, 1886. Licensed in California in 1886. Doctor Tully was a Retired member of the San Joaquin County Medical Society, and the California Medical Association.

## OBITUARY

### Charles Eaton Phillips

1877—1945

Charles Eaton Phillips, in practice in Los Angeles from 1914, passed away on Friday, June 15, 1945. A native of Millington, Illinois, and a graduate of the Medical School of the University of Illinois in 1903, Doctor Phillips served in the Panama Canal Zone during the period 1906 to 1913, beginning as an intern in the Ancon Hospital and advancing until he became chief of the surgical clinic in the Colon Hospital. During World War I he was a major in the Medical Corps of the United States Army, being stationed at Camp Dodge in Iowa, and the Walter Reed Hospital in Washington.

In his affiliations in Los Angeles he was prominently identified with the development of the surgical work in the Los Angeles County General Hospital, where for some twenty-four years he was a surgeon on the Senior Surgical Service. He was a member of the attending staffs of practically all the major hospitals in Los Angeles.

A much beloved member of the medical profession, and a strong supporter of scientific and organized medicine, his death brought sorrow to a host of patients, friends and colleagues.

A special committee of the Los Angeles County Medical Association paid tribute to his memory in the following words:

To Doctor Phillips death came merely to deepen the restful sleep of a tired man, "just tired out" by a lifetime of service in the medical profession; eight years as surgeon in Panama when the Canal was built, a quarter century as chief surgeon at the Los Angeles County General Hospital, as writer on medical and allied subjects, as teacher in wards and medical school, as originator and adapter of surgical techniques which made him famous among his colleagues, and above all as a general surgeon practicing his art with skill, understanding and sympathy.

He was universally respected, admired and esteemed

by the medical profession for his keenness of judgment, clarity of thought, and ability to meet difficult surgical emergencies by skillful use of trained hands and a thinking brain; by the general public for his unceasing thought for the well-being of patients in distress and pain.

He hated sham, half-truths and cynicism. In his writing his sharp wit and analytical probing brought revealing light into dark corners. His great surgical knowledge and his ability to talk understandingly brought him into law courts many times as an expert, relied on for his honesty and judicial judgment.

Among his colleagues he was loved and respected as few men are.

## CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

### Anniversary of the Army Medical Department

The Army Medical Department celebrated its 170th anniversary on July 27 of this year with the realization that it had grown into the largest organization of the kind ever known and that it is giving this nation's army the best medical care that soldiers have ever received.

From its inception in 1775 shortly after General George Washington became Commander-in-Chief of the Continental Army until the present day, the Army Medical Department has made steady progress in military medicine; it has made scientific discoveries that have benefited all of mankind; but never has its progress in both of these categories been so rapid as in recent years.

The Honorable Robert P. Patterson, Under Secretary of War, in a tribute to the work being done by the Medical Department under Major General Norman T. Kirk, The Surgeon General, recently said that no army at any time in history has achieved a record of recovery from wounds and freedom from disease comparable to that of the American Army in this war. Mr. Patterson said also that the Medical Department is attaining new records in almost every field of its endeavor. He cited the Army's record of saving nearly 97 of every 100 wounded soldiers who reach Army Hospitals, the disease rate of less than one in one thousand, and similarly startling figures with reference to malaria, the dysenteries, and other diseases, showing that the Medical Department has established effective control on all disease fronts. . . .

As an illustration of the remarkable advance of medical science in this war over other wars Major General Norman T. Kirk, The Surgeon General, recently cited the fact that in the Civil War the armies of the Union and Confederacy lost 336,216 men from disease; in World War I, deaths from disease totaled 62,670; but the rate in this war is only .6 of one man per 1,000 men per annum—or 12,000 deaths from disease since the war started.

### Major Craighill Reports on Health of Army Women Overseas

Major Margaret Craighill, MC, Consultant to The Surgeon General for Women's Health and Welfare, returned to Washington, D. C., this month from an eight-month inspection trip of WAC and medical installations during which she covered approximately 56,000 miles of the war zones. . . .

Major Craighill stated that in general the health of Army women overseas is excellent—even better than that of the men in many places because they have been given



a better break in living conditions. She found that illnesses are more prevalent among the older women and that the younger women are better able to adapt themselves to hardships and inconveniences. For this reason she expressed her personal opinion that women over thirty-five should not be sent overseas unless they were needed for top administrative posts.

There is no need to be concerned about the effect of either cold or tropical climates on American women, she said, although she believes that they should not be left in difficult climates overseas for more than two years.

Major Craighill, who was the first woman to be commissioned in the Army Medical Corps, was formerly dean of Woman's Medical College of Pennsylvania, Pa.

### **President Truman Signs Bonus Bill for Medical Personnel**

President Truman on July 7 signed legislation giving non-combatant Army Medical Corps personnel serving in the front lines the same \$10 a month bonus paid to combat infantrymen.

The War Department previously awarded front-line Medical Corps men a badge similar to that provided expert infantrymen who are entitled to the extra \$10 a month.

### **"Sulfa" in Wounds Discontinued**

The Army's accumulated experience in wound management does not justify the local use of any chemical agent in a wound as an anti-bacterial agent, according to the Office of The Surgeon General. The local use of crystalline sulfonamides (sulfa powder) has therefore been discontinued except in the case of serious cavities where its use, while permissible under the direction of the surgeon, is not recommended. This subject is covered by War Department Circular No. 160 as amended by W.D. Circular No. 176, 1945.

### **Health of Troops in U.S.A. Is Excellent**

During this past winter and spring the health of troops stationed in the United States has been excellent, surpassing that of any previous war year. The low hospital admission rate for all diseases reflects fewer communicable conditions, as it is during this period of the year that infectious diseases usually predominate.

There were less respiratory diseases than in any previous war year, although during May there was a slight rise in these cases. Pneumonia, measles, scarlet fever, meningitis, and rheumatic fever were all less prevalent than during the winter and spring of 1944. The only important infectious diseases of which this was not true were venereal diseases and infectious hepatitis.

Relapses in the United States of malaria infections acquired in tropical areas overseas increased each month until March, 1945, but have since declined slightly. With malaria control in all overseas areas now greatly improved, the number of relapse cases should continue to decrease.

The fact that most of our troops are well seasoned and there are fewer newly inducted troops is responsible in part for this improved health record. Most Army hospital beds here are now occupied by patients evacuated from overseas.

### **President Truman Told More Doctors Are Needed for Postwar Period**

Shortly after conferring with President Truman, a special committee of the Committee on Postwar Medical Service of the American Medical Association sent a

memorandum to the chief executive, pointing to the country's failure to "provide for the training of enough physicians to meet the demands for doctors which we know will increase after the war."

The memorandum, mailed to the President recently and published in full in the July 21 issue of *The Journal of the American Medical Association*, was prepared by four physicians—Evarts Graham, St. Louis; Harvey Stone, Baltimore, and Victor Johnson and Fred C. Zapffe, both of Chicago.

The memorandum said in part:

"Even if admissions, enrollments and graduations from our medical schools should continue at the present war-time levels, only about half of this need would be met, since 40,000 students will receive the M.D. degree in the period 1942 to 1948 and 24,000 physicians will have died during that time. Thus, under the most favorable conditions only about 16,000 additional physicians will be available after the war to do the work of 30,000.

"In spite of this, freshmen enrollments in the medical schools of this country will be drastically reduced within the next year. In the past year virtually no able bodied males have been permitted to commence the two year course of college premedical studies because the Army and Navy have ceased assigning men to such studies and the Selective Service System has discontinued deferments of premedical students. In the past few years each freshman class of about 6,000 students included 4,000 to 5,000 able bodied men. These are no longer available under existing regulations.

"This deficiency can be corrected under the present Selective Service Act as follows: Defer qualified men now in college premedical studies when they reach 18 and defer 8,000 selected high school students of this year to commence college studies in premedicine. From these, 4,500 should be earmarked for admission to specific medical schools a year later. Repetition of this procedure each year the war lasts would effect the training of enough doctors to care for the health of the people. Consideration might also be given to the assignment of a limited number of men now under arms back to premedical studies, provided they pursued such studies satisfactorily before induction, as far as this may be consistent with military necessity."

### **Army to Free 7,000 Doctors by May, 1946**

The Army promised on July 11 to reduce its doctors by 7,000 by May, 1946—a rate of demobilization that was criticized by a Senate subcommittee as too low.

Plans for releasing doctors were disclosed at the committee's hearing on the relative needs of the civilian population and the Army for medical care.

Senator Johnson (D., Colo.) said "the leisurely attitude of the Army toward this problem is something that this committee ought not to accept lying down."

Brigadier General Robert W. Berry, representing the War Department took exception "to the use of the word leisurely," but Johnson reiterated he thought it was "the right word."

"There is a tragic and critical need for these doctors in our communities," put in Senator Downey (D., Calif.), subcommittee chairman.

Testimony brought out that the Army now has about 45,000 doctors and that, including those in the Navy and the Veterans' Administration, the total serving the armed forces is approximately 60,000.

In active civilian practice, by comparison, were roughly 74,000 doctors, although another 20,000 are in salaried jobs with State hospitals and industrial plants, or are serving as interns.

Berry told the committee the Army death rate from

sickness was six-tenths of a man per 1,000 a year, adding this is "the finest record any Army in any war ever attained." With fewer doctors, he said, "deaths would have skyrocketed."—*San Francisco Chronicle*, July 12.

### 900 Doctors Released by Army, but—

Senator Downey (D., Calif.) on July 18, stated that, while the Army may have released 900 medical officers since January 1, 1945, as it recently announced, it has taken in 1,500 others in that time.

"Thus there are more medical officers on duty now (in the Army) than were in January, 1945, despite the defeat of Germany," Downey asserted.

Downey, chairman of a military affairs subcommittee investigating use of the Army's medical personnel, said in a statement that he had been informed the released officers fall into five categories:

(1) Officers incapacitated for any real work; (2) those dismissed after court-martial; (3) officers permitted to resign in lieu of being reclassified; (4) officers released for personal hardships "in many instances so severe as to prevent the individual from doing much work in private practice;" (5) some 50 to 100 individuals released so that they can minister to civilians.—*San Francisco Chronicle*, July 19.

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

### The Doctors' Voluntary Health Plan for Nation

Now the physicians of the nation have advanced their own voluntary health insurance plan.

It frankly is an effort to forestall government action for socialization of medicine.

The success of the physicians' own proposals undoubtedly will depend in large measure upon the thoroughness with which they push their program. They must remember that vigor is required. The public must be convinced that voluntary health insurance is better than regimentation.

And it must not be forgotten that socialized medicine is being advocated most vigorously by certain political elements who continually are conducting an all-out campaign for regimentation of this entire nation. These elements will not rest a minute. They have some sincere converts to their belief, but many of them are motivated by selfish aims.

The American Medical Association, therefore, not only must prove that its 14-point program is adequate but also must be on guard against the highly glamorized counter-propositions from political sources. The public easily can be confused on this vital issue and possibly induced to believe that a State or Federal program of medicine would be preferable to a voluntary one.

The A.M.A. rightly adopts the traditional American principle of local initiative in its suggestions for hospitalization and sickness insurance. Its insistence that these insurance plans be of a local nature will assure the type best adapted to each locality. That would be one of the great difficulties in any State or Federal sickness insurance plan—trying to adapt it to crowded cities and sparsely populated rural areas under some inflexible overall plan. We saw the evils of such attempted administration in the days of depression relief under the New Deal.

Many local plans of health insurance already have proved highly successful. They undoubtedly can be improved upon as they are extended and more experience is gained. They will tend to retain the traditional personalized relationship of family doctor and patient.

Another advantage of voluntary local plans is that the people who actually are to benefit share the cost. Under certain governmental plans the taxpayer would be saddled with a burden which would not provide equal benefits. In other words, governmental plans probably would impose upon a member of some private group—who already was protected with health insurance—the same cost as upon his neighbor who had no such protection.

The doctors take note of the indigent problem by recommending local insurance plans in addition to the present county hospital setups and the like.

Now the lines have been drawn.

The Family Physician vs. the Government Doctor.

In the final analysis the public must make its choice.—Editorial in *Los Angeles Times*, July 28.

### Health Insurance Problems in U. S. Given Scientific Study

*Research Men Report Lack of Specific Information to Determine Exact Need For Medical Care*

Compulsory health insurance with all its broad ramifications is reviewed in the July 21 issue of *The Journal of the American Medical Association* which says, editorially, that it "is offered as a report of a scientific investigation into the forces now promoting the mechanism for medical service incorporated in the Wagner-Murray-Dingell bill."

*The Journal's* article, prepared by Carl W. Strow and Gerhard Hirschfeld, Research Consultant and Director, respectively, of the Research Council for Economic Security, sheds light on various national health problems in order that a better view might be obtained on the subject of compulsory health insurance. . . .

Strow and Hirschfeld emphasize in *The Journal* article the need for careful deliberation, both by the government and various states, with regard to current or contemplated proposals for compulsory health insurance. . . .

The authors state that during the legislative sessions of 1945, more than thirty measures proposing cash sickness benefit plans or compulsory health insurance systems were introduced in 12 state legislatures. Other bills called for studies of health insurance, and in Congress a number of bills were introduced providing for some sort of medical care or sickness benefits.

"The demand for compulsory health insurance," the authors said, "has been more consistent and more pronounced in some states than in others. New York, for instance, has had no fewer than 27 health insurance bills introduced in the legislature between 1935 and 1945. Yet New York has far better medical and hospital facilities, as well as provision for social services, than the average state. On the other hand, such states as Mississippi, Georgia, Alabama, Arkansas and the Carolinas, where the need for medical care is most acute, have practically no organized demand for compulsory health insurance."

"Since 1935 and including 1945," *The Journal* article said, "102 bills have been introduced into the legislatures of 20 states, with success only in Rhode Island, in 1942. The passage of the National Social Security Act in 1935 was largely responsible for the increased activity."

The two research men said it was difficult to form an exact conclusion on what the public thinks of the problem of health insurance.

"Public opinion polls would indicate that the public favors health insurance," they said, but added cautiously: "However, this depends on the form in which the question is submitted. If it emphasizes benefits, public opinion favors health insurance. But when the question emphasizes the financial cost, the necessary tax burden and the economic consequence in general, the public seems to be less sure about the desirability of a compulsory system."



"Notwithstanding the large amount of voluntary protection against illness, there is no disagreement among the advocates of compulsory health insurance, as well as the opponents, as to the need for better medical care. The disagreement is about the form, the administration, coverage, benefits and many other details. . . .

"The health problem differs in virtually every state. In California, communicable diseases account for a major share of reported illnesses. In Mississippi influenza, syphilis, malaria, gonorrhea and dysentery are high on the list of reported illnesses. In New York cancer, syphilis, tuberculosis and pneumonia are the important health problems. . . .

In conclusion, the researchers said:

"The demand for compulsory health insurance is promoted most powerfully by organized collective action, especially by organized labor. . . . Apparently, the opportunity to organize the demand is more important than the prevalence of the need for medical care. The evidence points to the probability that, contrary to popular belief, the legislative proposals for compulsory health insurance are based not so much on social needs as on political interests, and that the ability on the part of labor to organize and press the demand, rather than the concern about the state of health, is the primary consideration. . . .

"Illness apparently is not chiefly responsible for the demand for compulsory health insurance. If it were, recommendations would start in the medically least progressive states. However, they originate at the opposite end of the scale, where medical care and social services are most highly developed."

### Proposed Health Bill by Kaiser

#### *Voluntary Plan Would Operate Through FHA*

Henry Kaiser has prepared a bill for introduction in Congress by Senator Claude Pepper (D., Fla.), that would permit establishment of voluntary systems for prepaid medical care throughout the country through the facilities of the Federal Housing Agency.

This was disclosed to the San Francisco Chronicle on July 18 with the information that the measure is about to be introduced as an amendment to the National Housing Act.

The bill is an outgrowth of Kaiser's experience in providing group health insurance to 125,000 employees monthly through the Kaiser Permanente Foundation.

#### Talk With Senators

Kaiser recently conferred with Senators Pepper, Murray (D., Mont.), Hill (D., Ala.) and Taft (R., Ohio) at an executive subcommittee session, he revealed after Chronicle inquiry, and "their questions indicated they had no serious objections to the plan."

The measure provides:

1. Guaranteed local bank loans to groups interested in setting up facilities for prepaid medical care.

(Under this provision a group of physicians, or a non-profit organization limited to labor, management and labor-management groups, or states and political subdivisions, could obtain a 90 per cent loan on a hospital property for group medicine.)

2. Technical assistance to the F.H.A. by the U. S. Public Health Service in determining the need and likelihood of success of the individual project.

3. Limitations upon the F.H.A. administrator, barring him from exercising any supervision or control over the administration, personnel or operation of the facilities except where specifically provided by law.

4. Preference for utilizing existing private or public facilities, and preference—in case two applicants seek to establish a medical facility in the same area—of the more complete plan.

### Typical Case

As explained by Kaiser, a typical case might be as follows:

"Suppose ten service doctors who had learned to work together wanted to continue their work in private life. Each of them might have \$2500—they could borrow that much under veterans legislation.

"They pool their \$25,000 and use it as the down payment on a guaranteed loan on a hospital property, say a 60-bed hospital capable of serving a population of 10,000. They give the F.H.A. a 4½ per cent mortgage on the hospital property.

"Then they go, for example, to ten manufacturers or merchants employing a thousand people each. These employers agree to deduct 10 cents a day from the pay check of employees who subscribe to the plan.

"Ten cents a day from 10 000 subscribers is a thousand dollars a day income, or \$365,000 a year. This should supply the doctors' and nurses' salaries and amortize the loan. It would provide voluntary health insurance for the 10,000 people.

"The F.H.A. has had a very successful experience in insuring home loans, why not for the purpose of providing health homes?" he asked.

### Deadly Serious

Kaiser said he was "deadly serious" in an effort to provide a public health measure that not only would encourage maximum initiative on the part of the medical profession but would also limit to a minimum any interference by Government agencies.

"The practice of preventive medicine is assured by providing the doctors with a regular income which compensates them for keeping their subscribers healthy rather than for treatment of illness," he wrote Senator Pepper.

"The prepaid medical plans made possible under the bill will operate as business enterprises, motivated by the impelling force of competition.

"This is not socialized medicine in the sense of a social experiment," he added. "The medical service rendered by the Permanente Foundation is fully equipped with the facilities required by the science of medicine and is wholly self-supporting and self-amortizing. This bill is a projection of that experience."

Kaiser said that since the bill provides a method for stabilizing and rationalizing the economics of medical practice, within the system of free private enterprise, he felt it should not meet objection from the medical profession.

He said he believed such a measure was necessary to provide group practice, with its various specialized forms, at low, regular cost to the subscribers. He cited that "prepayment relieves subscribers from financial inhibitions and encourages them to consult their doctors early and often."—Fred Duerr, in *San Francisco Chronicle*, July 19.

### Governor Warren Signs Clinic Site Bill

First step in what is expected to develop into an important psychiatric institution in Los Angeles was taken on July 19, according to Dr. George Thompson, chief psychiatrist of General Hospital, when Gov. Warren in Sacramento signed a bill appropriating \$100,000 to buy a site for a psychiatric clinic.

The clinic will be patterned after the Langley Porter Clinic established by the State three years ago in San Francisco.

There is no way to estimate the cost of the building and equipment but it probably will be in the neighborhood of \$500,000.

The clinic will be devoted to research, teaching and treatment.

## COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

### San Francisco Group Plans Institution for Chronic Sick

San Francisco will have an institution for the care and treatment of the chronic sick, the first of its kind in this region, if present plans of the Federation of Jewish Charities here materialize.

The project is the outgrowth of studies indicating that sufferers from paralysis, arthritis, diabetes, heart disease and other ailments, lack adequate medical attention here, because of a shortage of specialized facilities in the community.

Under present plans, patients would receive all benefits of modern medical therapy for as long as necessary. The institution would serve free, part pay and full pay cases.

Conceived as a separate entity under the Federation of Jewish Charities, nevertheless it is expected that the Mt. Zion Hospital staff will furnish required medical care. . . .—San Francisco *Chronicle*, July 16.

### Los Angeles Blue Cross Plan

At least two and a half million Blue Cross members will receive more complete prepaid hospital care as the result of recent sweeping contract changes by nine Blue Cross plans. . . .

Two geographically-opposite plans also recently revised their contracts to include more complete subscriber services—Wilkes-Barre, Pa., for the eleventh time in less than seven years and Los Angeles, Calif., for the third time in three years. . . .

#### Third for Los Angeles

The third liberalization of benefits by the Blue Cross plan in Los Angeles means an extra 180 days of hospital care at 50 per cent discount in addition to the 21 provided annually for each illness or injury of separate cause. The first increase in subscriber benefits by this plan occurred about three years ago when all waiting periods for needed services were discontinued, and conditions existing at the time of joining were immediately covered for hospital service. The second liberalization came a year and half ago when the plan announced the inclusion of maternity benefits in all family contracts.—“Blue Cross Bulletin,” Vol. VIII, No. 6, June-July, 1945.

### Every Two Seconds a Patient Admitted to Hospitals

Americans entered hospitals as patients at the rate of one person about every two seconds last year, not counting the babies who were born in hospitals at the rate of one live baby every 16.4 seconds, the American Medical Association's 24th annual hospital census shows.

The 16,063,848 admissions to hospitals, exclusive of outpatients and newborn infants, is called “unprecedented” by Dr. F. H. Arestad and Dr. M. G. Westmoreland, in their report of the facts and figures on hospitals.

About one-fourth of these admissions, 4,287,271, were to federal hospitals and 2,257,949 to other governmental institutions.

The number of registered hospitals decreased to 6,611, which is 44 less than for 1943, but the number of beds increased to a total of 1,729,945.

In contrast to the feeling some patients may have had that they were being hustled out of the hospital pretty fast after an operation or the birth of a baby, to make room for the next patient, is the figure showing that in general hospitals the average length of stay per patient increased by one-half day.

Of the 1,919,976 babies born in hospitals last year, 96.7 per cent were born in general hospitals, with only 3.2 per cent born in maternity hospitals and 0.1 per cent in other institutions. The number of babies born in hospitals has more than tripled in the past 15 years.—San Francisco *News Letter*, May.

### Adult Respirators in California

Publication No. 24-C of The National Foundation for Infantile Paralysis, Inc., 120 Broadway, New York 5, N. Y., on “Respirators, Locations and Owners” was recently issued.

“The list of adult cabinet type respirators or ‘Iron Lungs’ has been compiled from records available May 1, 1945. It contains only those respirators which have been approved by the Council on Physical Medicine of the American Medical Association. The list is not complete for it does not give consideration to transfer and resale of machines, nor have all that are worn out been removed. These standard cabinet type respirators are not to be confused with other machines such as chest type respirators, resuscitators, inhalators or aspirators.”

California is second in the States in the Union with number of standard respirators, the list in the five states having the largest number being as follows: New York, 159; California, 86; Pennsylvania, 81; Illinois, 59; Texas, 55.

The location list for California follows. Unless otherwise indicated, there is one (1) respirator. Counties follow names of cities, in parenthesis.

#### CALIFORNIA

Arlington ( <i>Riverside</i> )	...Riverside County Hospital
Auburn ( <i>Placer</i> )	.....DeWitt General Hospital (Owned by U. S. Army)
Bakersfield ( <i>Kern</i> )	.....Kern County General Hospital ..... (3)
Berkeley ( <i>Alameda</i> )	...Berkeley Hospital
Carmel ( <i>Monterey</i> )	.....Peninsula Community Hospital
Chico ( <i>Butte</i> )	.....Fire Department
Daly City ( <i>San Mateo</i> )	..Villa Hospital
El Centro ( <i>Imperial</i> )	...Imperial County Farm and Hospital
Eureka ( <i>Humboldt</i> )	...Humboldt County Hospital
Fresno ( <i>Fresno</i> )	.....General Hospital of Fresno County ..... (2)
Hanford ( <i>Kings</i> )	.....Kings County Hospital
Hollister ( <i>San Benito</i> )	..Hollister City Hall
Lompoc ( <i>Santa Barbara</i> )	.....Camp Cooke (Owned by U. S. Army)
Long Beach ( <i>Los Angeles</i> )	.....Seaside Memorial Hospital
Los Angeles ( <i>Los Angeles</i> )	.....Children's Hospital Hospital of Good Samaritan Los Angeles County General Hospital ..... (7) (2 owned by Los Angeles County Chapter of the National Foundation)
Martinez ( <i>Contra Costa</i> )	.....Contra Costa County Hospital
Marysville ( <i>Yuba</i> )	.....Camp Beale (Owned by U. S. Army)
Modesto ( <i>Stanislaus</i> )	...Hammond General Hospital (Owned by U. S. Army)
Montreay ( <i>Monterey</i> )	...Fort Ord (Owned by U. S. Army) Monterey Hospital
Oakland ( <i>Alameda</i> )	...Alameda County Hospital.. (2) Children's Hospital of the East Bay



Orange ( <i>Orange</i> )	Orange County Hospital
Palo Alto	
( <i>Santa Clara</i> )	Palo Alto Hospital
Pasadena	
( <i>Los Angeles</i> )	Collis P. & Howard Huntington Memorial Hospital
	Pasadena Regional Hospital
	(Owned by U. S. Army)
Redding ( <i>Shasta</i> )	Shasta County Hospital
Richmond	
( <i>Contra Costa</i> )	Permanente Field Hospital
Sacramento	
( <i>Sacramento</i> )	Sacramento County Hospital
	Sutter General Hospital
Salinas ( <i>Monterey</i> )	Monterey County Hospital
San Bernardino	
( <i>San Bernardino</i> )	The Argonauts Breakfast Club
San Diego ( <i>San Diego</i> )	Mercy Hospital
	San Diego County General Hospital
	..... (3)
	(1 owned by San Diego County Chapter of the National Foundation)
	United States Naval Hospital
	..... (2)
San Francisco	
( <i>San Francisco</i> )	Children's Hospital
	..... (5)
	French Hospital
	Harbor Emergency Hospital
	Isolation Hospital
	Letterman General Hospital
	(Owned by U. S. Army)
	Mission Emergency Hospital
	Mount Zion Hospital
	Park Emergency Hospital
	San Francisco Hospital
	..... (6)
	Stanford University Hospital
	..... (2)
	(1 owned by San Francisco County Chapter of the National Foundation)
	University of California Hospital
	..... (2)
San Jose ( <i>Santa Clara</i> )	Santa Clara County Hospital
	..... (2)
San Mateo ( <i>San Mateo</i> )	Mills Memorial Hospital
	San Mateo Community Hospital
San Miguel	
( <i>San Luis Obispo</i> )	Camp Roberts
	(Owned by U. S. Army)
Santa Barbara	
( <i>Santa Barbara</i> )	Hoff General Hospital
	St. Francis Hospital
Santa Cruz	
( <i>Santa Cruz</i> )	Mrs. W. N. Swazey
Santa Rosa ( <i>Sonoma</i> )	Sonoma County Hospital
	..... (2)
Stockton ( <i>San Joaquin</i> )	San Joaquin County Hospital
Tulare ( <i>Tulare</i> )	Tulare County General Hospital
Vallejo ( <i>Solano</i> )	Vallejo Community Hospital
West Oakland	
( <i>Alameda</i> )	Permanente Foundation Hospital

### Northwest Leads in Medical Insurance

The leading position of Washington and Oregon medical societies in prepayment plans for medical care was studied firsthand by the executive secretary of the American College of Radiology at a regional conference of the A.M.A. Council on Medical Service and Public Relations in Portland, April 7, 1945.

The secretary stated, in the Northwest, medical societies and hospital groups have controversies similar to those in other sections of the country. But there the typical situation is reversed. Medical societies preceded hospitals in providing group hospitalization and medical service plans. They are now objecting to efforts by Blue Cross to move in.

The Kings County Medical Service Bureau, Seattle, has built its own hospital to provide hospitalization for the subscribers to its medical care plan. The Klamath Medical Service Bureau, Oregon, has done the same.

Doctors controlling the county society medical service bureaus in Washington and Oregon see no reason why they should surrender control of prepaid medical care to Blue Cross, so long as their present plans are adequately fulfilling local needs. With 14.2 per cent of its population covered by medical care insurance, Oregon leads all other states in percentage of population enrolled. Washington is second with 12.9 per cent covered.

Officers of Oregon Physicians Service charged that, "Despite denials to the contrary by Blue Cross authorities, there had been several definite instances of attempts made by hospital organizations or their representatives to intimidate, dominate, or control the medical profession or to subordinate the profession to hospitals or health centers."

### Five-Million-Dollar Expansion Planned for Letterman

*Letterman Hospital of San Francisco to Be Nation's Biggest Debarcation Unit*

A \$5,000,000 expansion program for Letterman Hospital which will make it the largest debarkation hospital in the country was announced on July 27, by Brigadier General Charles C. Hillman, commanding officer of the hospital.

Headquarters of the Western Defense Command, now skirting the parade grounds, will be moved to Fort Winfield Scott.

The expansion program is expected to be completed within six months.

The Letterman Hospital reservation then will have 8,500 beds as compared with 3,100 at present.

Patients debarking from Pacific transports—both ships and planes—will stay at Letterman from five to six days before being transferred by train to hospitals nearest their homes—an average journey of 2,300 miles.

Twenty thousand patients can be handled monthly when the expansion is completed.

Fifty stucco buildings, containing 36 wards, two recreation centers, a theater, a chapel, a heating plant, and administration building, will be constructed along the bay on the old Crissey Field site.

All buildings will be connected by a central ramp.

A fishing pier will be built into the Bay for patients' use.

General Hillman said there would be a proportionate expansion of the hospital train unit.

There are now four tracks laid on Crissey Field to accommodate hospital trains. These will be connected with all parts of the hospital by covered ramp so patients may be wheeled from their beds directly to the train, eliminating the present ambulance trip.

In addition, a heavy shop for repair of hospital cars will be constructed at the far western end of the field.

Personnel of the hospital train unit will be increased to 3,000. Six thousand persons will be needed to operate the enlarged facilities. Fourteen hundred additional civilians will be required.

At present there are 1,200 enlisted men and 900 civilians employed. After expansion 3,000 soldiers and 2,000 civilians will be needed. The Letterman compound will house a total of 15,000—operating personnel and patients.

Dante Hospital at Van Ness Avenue and Broadway, now a Letterman annex, will be used solely for local admissions. The present Letterman Hospital will treat surgical and psycho-neurotic cases and the Crissey Field addition will handle all other cases.

Two large concrete buildings, now used as Western Defense Command headquarters, will be devoted to hospital beds. The brick buildings along the parade ground will be used as barracks for military personnel connected with the hospital. Increased number of casualties demand the expansion, General Hillman explained.\*

In the first half of last year, he said, casualties from all theaters of war totaled only 9,000 a month. In May of this year alone, 57,000 wounded and ill men were debarked from fighting fronts—9,100 at San Francisco.

### Permanente Hospital in Oakland is Opened to Public

#### *Prepaid Medicine*

Henry J. Kaiser's Permanente Foundation Hospital in Oakland, built to provide prepaid medical care for 100,000 shipyard workers, has been opened to the public.

Clyde F. Diddle, administrator of the \$2,000,000 hospital at Broadway and MacArthur Boulevard, said on July 20, that any individual may walk into the hospital and apply for complete, prepaid medical care.

Groups of 25 workers under one employer may also obtain medical service. The 300-bed hospital has 80 full-time physicians and surgeons, laboratories, clinics and pharmacies.

#### Four-Point Plan

The Permanente Foundation, with hospitals at Oakland, Richmond, Fontana and Vancouver, operates under principles involving four points, Diddle said.

These are: pre-payment, group practice, adequate facilities, and "a new medical economy."

This "new economy," strongly opposed in part by some factions favoring the traditional family physician-patient relationship, follows the old Chinese practice of paying the physician while you are well.

"We offer medical service from nasal spray to surgery—and all under one roof," said Diddle. "The important thing is that there are no barriers to early treatment."

"There is a tendency, because of the cost of medical care, to let things go—to visit the doctor as little as possible and only when you are in desperate need."

"Those who believe in the new economy emphasize preventive medicine. Under the Foundation plan, patients are encouraged to come in early to shorten the treatment."

Diddle said the hospital, now released from the pressure of meeting the medical needs of some 50,000 shipyard workers who have left the yards in the past six months, has become the only hospital in the nation handling industrial accident cases on a contractual basis.

#### Prepaid Care

Under this contractual system, the hospital receives a percentage of accident insurance premiums and provides, in return, care for the insurance company's clients' injured workers. It is another form of prepaid medical care.

"In another way, we are trying to continue the type of medical care Army and Navy men learned to expect in four years of war—the opportunity to drop in at a well-equipped, well-staffed hospital and receive treatment for anything from a scratched finger to a serious illness," Diddle explained.

It was disclosed on July 19 that Henry Kaiser was preparing a bill for introduction in Congress to permit establishment of voluntary systems for prepaid medical

care throughout the country through the facilities of the Federal Housing Agency.

Diddle said that a 60-bed infirmary, named the Permanente Medical Center, was recently opened at Vallejo as an extension of the foundation's medical services.—*San Francisco Chronicle*, July 21.

### Kaiser Widens Medical Plan

#### *Permanente System Extended in Vallejo*

Permanente Foundation, the Henry Kaiser prepaid medical plan, has been expanded to include a large group of persons not on company payrolls, with the extension of services to eight Vallejo area housing projects, it was revealed today.

The new medical center will be established in the wing of the present public health service infirmary. It will be open from 10 a.m. to 10 p.m., with service available at night on call.

A physician will be assigned to each dormitory.

This medical center has a potential membership of 25,000, according to company estimates.

The health plan expansion marks the beginning of efforts under way by the Kaiser organization to offer Permanente Foundation facilities to all groups interested in prepaid medicine.

A million and a half dollar addition made to the Permanente Hospital, Broadway and MacArthur Boulevard, Oakland, made the present extension possible, the company announced.—*San Francisco News*, July 17.

### Kaiser on Prepaid Medical Care

Henry J. Kaiser on July 20 called on San Francisco business leaders to approach reconversion in a spirit of boldness "uninfluenced by the rumors of depression, deflation, disorder or revolution."

He spoke to a Chamber of Commerce luncheon on "Post-War in Prospect," asserting that the West is in the van of great industrial development, that San Francisco faces the same challenge in peace that it did in 1906 after the fire. . . .

On the subject of prepaid medical care, he asked "Why can't we lead the way in providing the best in medical facilities to be within reach of all?"

"Just across the bay we have a laboratory, or shall I say a model, which has been studied by medical authorities and public health officials from all over the nation and from a number of foreign countries."

"The confidence and commendation which has been expressed give us the faith to believe that this is a good idea. If only we could have at least one prepaid medical health center in every Western community, we could be assured that there really is to be a new world in which this priceless service becomes a right rather than a privilege." . . . —*San Francisco Chronicle*, July 20.

### Hospitalization of Communicable Diseases

Los Angeles City—July, 1945

(COPY)

DEPARTMENT OF HEALTH  
CITY OF LOS ANGELES

In accordance with Municipal Code of the City of Los Angeles (Sec. 32.12) which reads as follows:

" . . . Before such isolation ward may be installed, operated or maintained, an application in writing therefor shall be made to the Board of Health and the approval by the Board of the installation, operation and maintenance of such isolation ward shall be first obtained. Such isolation ward shall be used exclusively for the

\* With unconditional surrender of Japan, new building plans for Letterman will be held in abeyance.



isolation, care and treatment of persons affected with such communicable or contagious diseases. Such isolation ward shall, at all times, be operated and maintained in conformity with the rules and regulations of the Board."

1. Because of their communicability, none of the following diseases may be cared for in any hospital, sanitarium, or other common place of care of persons except the Los Angeles County General Hospital which has been duly authorized, or in other contagious disease units which may be authorized in the future:

Chickenpox	Pertussis
Cholera	Plague
Diphtheria (cases and carriers)	Polioomyelitis
German Measles	Psittacosis
Leprosy	Rabies
Leptospirosis	Typhus (Epidemic)
(Weils Disease)	Smallpox
Measles	Scarlet Fever
Meningococcic Meningitis	Tuberculosis
Mumps	(Infectious Stage)*
Paratyphoid Fever	Typhoid Fever
	Typhoid Carriers

\* Various institutions have been especially licensed to care for tuberculosis.

Note: Nothing herein is to be construed as demanding that any person with a communicable disease must go to the hospital. When hospitalization is necessary, however, only the Los Angeles County General Hospital is allowed to accept or keep such a patient. Any person infected with a communicable disease may remain at home, except in instances, when in the opinion of the Health Department, home conditions prevent isolation of the patient within the home.

2. Certain diseases because of their relative mildness or low communicability with the ordinary type of contact in institutions do not come under this classification, and therefore may be cared for in institutions using reasonable care to prevent their spread. These include:

Actinomycosis	Malaria
Ascariasis	Mononucleosis (Infectious)
Chancroid	Pediculosis
Choriomeningitis	Pneumonia
Coccidiomycosis	a. Pneumococcal
Dengue	b. Other Bacteria
Dysentery (Amoebic)	c. Primary Atypical
(Bacillary)	Relapsing Fever
Encephalitis	Rheumatic Fever
Filariasis	Typhus (Endemic)
Food Infections	Ringworm
(Salmonella)	Scabies
Food Poisoning	Streptococcal Infections
a. Staphylococcus	a. Erysipelas
b. Botulism	b. Puerperal Infections
Gonorrhea	Syphilis
Hookworm Disease	Tetanus
Infectious Hepatitis	Trachoma
(Catarrhal Jaundice)	Trichonosis
Impetigo	Tuberculosis
Influenza	(Non-Infectious)
Lymphogranuloma	Tularemia
Venerium (Inguinali)	Undulant Fever

3. All institutional outbreaks including epidemic diarrhea of the newborn and impetigo must be reported to the Health Department immediately and will be handled according to the demands of the situation.

4. Exceptions to this policy must be authorized by the Health Department. For example, in exceptional cases where the movement of a patient with an acute communicable disease will jeopardize his life, the Health Department may authorize, temporarily, that he not be moved.

The above rules were adopted by the Board of Health Commissioners June 7, 1945, on recommendation of the Medical Committee of the Board.

### 17,500,000 Americans Now Members of Blue Cross

One out of every seven Americans, as of April 1, 1945, is paying his hospital bills in advance through non-profit

Blue Cross plans serving 42 states, the District of Columbia, 7 Canadian provinces, and Puerto Rico. The 17,500,000 membership mark was passed as this year's first quarter growth of 1,000,000 persons broke all previous records.

Daily, 12,000 workers and family members, or 85,000 weekly, are adding their names to Blue Cross plan membership rolls as voluntarily-assumed protection against the unpredictable, and therefore burdensome, costs of hospitalized illness and injury. Coöperating are 350,000 employers who are either allowing payroll deduction or else paying part or all of the cost for employees.

The membership goal set for the close of this year by the 84 American Hospital Association approved Blue Cross plans across the nation is 21,000,000 persons, or a gain of 4½ million members during 1945. This gain would exceed by 1,000,000 the record growth of 1944.

### Three Plans Over One Million

Three Blue Cross plans report memberships of more than 1,000,000 persons: New York City, 1,950,000; Michigan, 1,243,950; and Massachusetts, 1,060,970. Eight additional plans report membership of more than 500,000 persons: Cleveland, 834,850; Chicago, 766,900; Pittsburgh, 753,700; Philadelphia, 722,000; New Jersey, 711,450; Minnesota, 617,200; St. Louis, 505,350; and Cincinnati, 501,960.

Only six states, containing but 5 per cent of the population of the United States, are now without hospital-sponsored Blue Cross plans. The four state-wide plans formed during the past year—Florida, Indiana, Utah, and Arizona—are spreading out rapidly to make protection available to the residents of these states.

### How They Join

Family dependents continue to exceed breadwinners in percentage of Blue Cross membership (54.8 and 45.2). Workers join for themselves and their families through their place of employment: industrial plants, factories, stores, offices, private and public institutions, professional groups, and farm and community organizations.

Twenty-nine Blue Cross plans now accept as members individuals who are self-employed, domestics, unemployed, or retired.

More than 425,000 hospital bills were paid by Blue Cross plans during the first three months of this year, the costs of which exceed \$22,250,000. The daily admission rate for Blue Cross patients totaled more than 5,000. —"Blue Cross Protection," Vol. 2, No. 1, Spring, 1945.

### Commission on Hospital Care

#### *A Non-Government Public Service Committee to Study Hospital Service in the United States*

*America's First Hospital Inventory—1945.*—For the first time in our history a complete inventory of our nation's hospitals is being taken. This inventory is part of a broad hospital study under the direction of the Commissioner on Hospital Care, 22 East Division Street, Chicago 10, Illinois.

Besides taking inventory of the 1945 hospital, the Commission on Hospital Care is analyzing economic, geographic and population factors—all of which have a direct bearing on postwar hospital construction and the future quantity and quality of hospital service throughout the country.

*The Commission on Hospital Care—What It Is.*—The Commission on Hospital Care is not an official public enterprise. It is not a private organization. It is neither —yet it is both.

The study is being conducted as a coöperative effort of government and voluntary hospital interests to discover the facts about the nation's hospitals.

The Commission was inaugurated by the American Hospital Association, is financed by funds from private resources and is sponsored by state and regional hospital organizations.

It is assisted in its work by the United States Public Health Service which has made technical personnel and physical facilities available to the staff. Also, state health departments have offered assistance and in some instances are actually conducting the studies.

*The Commission on Hospital Care—How and Why It Began.*—The unplanned growth and haphazard distribution of hospitals throughout the country is a situation which hospital people have been considering for a long time. Members of the American Hospital Association believed that complete inventory of all establishments offering bed care for the sick was basic to the planning and development of a coördinated hospital system.

They inaugurated a new organization, the Commission on Hospital Care. It is broadly representative of professional and public groups. It operates independently of any single organization. The Commission on Hospital Care is completely free from opinion and prejudice and is able to do the fact-finding job on a truly impartial basis.

Its members and its technical staff approach the problem with no preconceived plan. They are united and guided by a sincere interest in finding the facts. The study is financed by the W. K. Kellogg Foundation, The Commonwealth Fund, and The National Foundation for Infantile Paralysis.

*The Hospital—"Doctors' Workshop."*—A century ago the hospital was a dreary shelter for the destitute. Today it is the brisk, shining center of all society's life-giving and life-saving activities.

It was the lightning development of medical science that rocketed the hospital into this new position. Medicine's newer methods required the use of complicated machinery, expensive pilot study.

The Director of Study is A. C. Bachmeyer, M.D., and associated with him are Maurice J. Norby, Director of Research; Robert C. Morrey, M.D., Assistant Director, Surgeon (R) United States Public Health Service, and C. Horace Hamilton, Ph.D., Director of Sociological Research.

The roster of some 21 members of the Commission includes the names of two Californians:

Wilton L. Halverson, M.D., Sacramento; Director of Public Health, State of California; and

Herbert Hoover, Stanford University, California; Trustee, Stanford University [Stanford University Hospital].

### "Blue Cross and the National Scene"\*

The Blue Cross Plans for protection against the costs of hospitalized illness have enrolled more people in less time than any voluntary program in the history of the world.

This movement began as a cautious experiment in the law of averages. Ten years ago there were approximately 100,000 Americans budgeting their hospital bills through voluntary, non-profit prepayment plans which offered free choice of institutions. At the present time 18,000,000 persons—nearly one-seventh of our civilian population—are covered by Blue Cross Plans in 43 states and seven provinces.

Blue Cross protection is available in 3,500 member hospitals which constitute 85 per cent of the bed capacity

open to the general public for acute illnesses. The movement is sponsored by 1,500 civic leaders from industry, labor, welfare, hospitals and the medical profession. These trustees serve without pay; their only reward is the satisfaction of performing a public service through which Americans can place hospital care in the family budget along with other necessities.

### From Experiment to Example

Blue Cross has now moved from the area of cautious experiment to the field of courageous leadership. Public acceptance has grown rapidly. In addition to the 18,000,000 members of Blue Cross Plans, an additional 8 or 10,000,000 receive more or less complete protection through industrial medical service and stock or mutual group insurance policies.

There are now 23 Blue Cross Plans coördinated with non-profit, medically sponsored prepayment programs for physicians' services. The number of such plans is increasing each month, and enrollment may ultimately reach the number of subscribers in hospital plans.

The coördination of medical plans with Blue Cross is consistent with the public's desire for protection against the full costs of hospitalized illness and with the elementary fact that medical attention and hospital care are interdependent factors in the diagnosis and treatment of illness.

The policies and methods of coöperation are in a formative stage, with different degree of administrative unity, which vary from completely identical to entirely separate corporations and personnel. The ultimate validity of any specific methods of coördination must be tested by public acceptance, quality of service, and the freedom of action and choice provided to physicians, institutions and patients. . . .

### Factors in Blue Cross Success

The Blue Cross method of furnishing health service is a product of two basic factors: *first*, the individual's "quest for certainty" in preserving and restoring his personal health; *second*, the community's recognition that sickness and accident are unpredictable by the individual, and hence require group action if health service is to be adequately distributed.

Health and hospital services are not a private commodity, whether considered from the point of view of available facilities, the general attitude of the public, or the history of the provision of hospital service.

The hospitals represent approximately \$4,000,000,000 of capital investment. They have been constructed predominantly from public funds, 95 per cent through voluntary philanthropic gifts or governmental taxes by local, state or national bodies. Adequate "stand-by" facilities are necessary to meet unpredictable health needs; hence entire communities have taken the leadership in providing them. Less than 5 per cent of the total hospital capital (2 per cent on the Atlantic Seaboard) has been provided by private investors who expected a return of, or interest on, their original investment. . . .

The public welfare demands that every individual be restored to reasonably good health as soon as possible. This basic factor underlay the practice of the sliding scale of fees when individual practitioners were the main source of medical knowledge and service; and it underlies the present custom throughout the world of permitting the entire population (with varying degrees of equity) full access to the publicly provided buildings, equipment and scientific apparatus in each community.

### The Approval Program

Twelve years ago the American Hospital Association recognized the value of the insurance principle for lightening the burdens of patients and stabilizing the income of hospitals. It is not the size, but the uncertainty, of

\* Excerpts from a paper by C. Rufus Rorem, Ph.D., C.P.A., Director Hospital Service Plan Commission, Chicago, Illinois, and presented at the Blue Cross Regional Conference, June 14-15, 1945, Philadelphia.



the hospital bill which makes it so burdensome for the person needing care. The uncertainty which makes it hard for the patient to pay his hospital bill also makes it difficult for hospital administrators and trustees to pay the bills of the institutions. Hospitals do not give service in order to get money; but they do need money in order to give service. The only question is: who shall pay the cost of hospital care and under what circumstances shall they do so?

The Association's approval of the insurance principle has been implemented by encouragement of hospitals to coöperate with prepayment plans; also guidance for community leaders in developing such plans by which the people could pay *their own hospital bills, with their own money, in their own institutions.*

A set of standards has been developed by the American Hospital Association which should characterize community-sponsored movements if the hospitals are to be urged to participate in them. These standards cover such points as non-profit organization, free choice of institution and doctor, reasonable charges to the public, adequate reimbursement of the hospitals, effective administration and control. Plans which meet these standards are permitted to identify themselves by a Blue Cross with the seal of the American Hospital Association superimposed upon it. Hence the name "Blue Cross Plan." The Blue Cross symbol was originated by Mr. E. A. van Steenwyk of Philadelphia, when he was administrator of the Minnesota Blue Cross Plan.

#### The Present Proposals and Prospects

Blue Cross success in reaching 18,000,000 Americans has brought a challenge to achieve protection for a much larger number of the employed population. At present eleven states have already enrolled 20 per cent or more of their total population. These include New York, New Jersey, Pennsylvania, Rhode Island, Delaware, District of Columbia, Connecticut, Ohio, Michigan, Minnesota and Colorado. In some metropolitan areas 50 to 65 per cent of the total population are enrolled under Blue Cross. There is need and opportunity for community leaders and the general population everywhere to do as well for themselves as other parts of our nation. . . .

## COMMITTEE ON POSTGRADUATE ACTIVITIES

### Public Health School on Berkeley Campus of U.C.

A graduate program will be inaugurated this fall in the school of public health on the Berkeley campus of the University of California under the direction of Dr. Walter H. Brown, acting dean.

A course in health education, leading to the degree of master of public health, will open the program. As the school develops, Dr. Brown says, it is planned to add graduate curricula in public health administration, epidemiology, sanitation, industrial hygiene, biostatistics, and public health laboratory.

"Since health education is one of the most rapidly expanding fields of public health and since the demand for competent persons to make the individual and the community intelligently aware of health problems is one of the most important public health needs, the University's school of public health is offering a graduate course in this field," Dr. Brown said.

Health educators work as regular members of health departments, or may be employed by schools or voluntary health agencies, the dean explained. Heading the new program on the Berkeley campus will be Dr. Clare E. Turner, visiting professor of public health education.

The course will be given in coöperation with the school of education as persons thoroughly prepared in a diverse group of sciences and arts are required. Instructors will be drawn from the schools of education, public health and medicine.

### Wartime Graduate Medical Meetings

Note.—The C.M.A. Postgraduate Committee presents below the roster of speakers and topics of "Wartime Graduate Medical Meetings." These listings may have suggestive value to program committees of Component County Societies.

#### CLINICS, DEMONSTRATIONS, LECTURES

Under the Auspices of the American Medical Association, the American College of Physicians, the American College of Surgeons

Authorized by the Surgeons General,  
Norman T. Kirk, Ross T. McIntire, Thomas Parran

#### Committee 24th Zone

Lt. Comdr. Geo. C. Griffith (MC), USNR, Chairman  
U. S. Naval Hospital, Corona  
Capt. Harry P. Schenck (MC), USNR  
Wayland A. Morrison, M.D.  
James F. Churchill, M.D.

Program of the Wartime Graduate Medical meetings for Zone 24 (Southern California) follow:

*Birmingham General Hospital, Van Nuys, Calif.—*  
3:00 p.m.

Aug. 8—"The Management of Simple Skin Diseases."—  
Lt. Col. Everett R. Seale.

Aug. 22—"Anesthesia in War Surgery."—Lieut. L. E. Trotter.

*Camp Haan, A.S.F. Regional Hospital—3:30 p.m.*

Aug. 7—"Surgery of the Liver and its Ducts."—Capt. E. E. Larson.

*March Field, A.A.F. Regional Station Hospital—*  
3:30 p.m.

Aug. 21—"The Treatment of Burns and Their Plastic Repair."—Capt. Harold T. D. Kirkham.

*Camp Cooke Station Hospital—1:00 p.m.*

Aug. 1—"The Rh Factor."—Capt. George Macer.

Aug. 15—"Psychosomatic Medicine."—Dr. H. Douglas Eaton.

*Hoff General Hospital—8:00 p.m.*

Aug. 1—"The Rh Factor."—Capt. George Macer.

Aug. 15—"Psychosomatic Medicine."—Dr. H. Douglas Eaton.

*U. S. Naval Hospital, Santa Margarita Ranch—1:00 p.m.*

Aug. 9—"Some Dynamics of Military Neuro-psychiatry."—Major Alex. Blumstein.

Aug. 23—"Intra-ocular Foreign Bodies."—Lt. Comdr. H. Lusic.

*U. S. Naval Hospital, Long Beach—3:00 p.m.*

Aug. 15—"Problems in Obstetrics."—Comdr. Wood.

*U. S. Naval Hospital, Corona, Calif.—1:00 p.m.*

Aug. 9—"Pulmonary Tuberculosis."—Comdr. W. L. Rogers and Comdr. A. W. Hobby.

Aug. 23—"Penicillin in Syphilis and Gonococcal Infections"—Lt. Comdr. W. W. Duemling.

*U. S. Naval Air Training Station, San Diego—3:00 p.m.*

Aug. 3—"Plastic Repair of Lesions of the Face and Neck."—Dr. Edward S. Lamont.

Aug. 17—"Communicable Diseases."—Major Norman Nixon and Capt. Charles Marple.

*Santa Ana Army Air Base Regional and Convalescent Hospital—4:00 p.m.*

- Aug. 7—"Peritoneoscopy."—Capt. J. C. Ruddock.  
 Aug. 21—"War Wounds of the Chest."—Lt. Comdr. J. P. O'Connor and Lt. Henry Jaffee.  
*U. S. Naval Hospital, San Diego, Calif.—1:00 p.m.*  
 Aug. 2—"Clinical Aspects of Rheumatic Fever."—Lt. Comdr. Geo. C. Griffith.

## C.M.A. CANCER COMMISSION

### Federal Cancer Fund Favored

Princeton, N. J., July 20.—The American public would favor a Congressional appropriation of \$200,000,000 for the study and treatment of the disease which ranks second only to heart trouble as a cause of death—cancer. Three out of four Americans say they are willing to pay more taxes to provide this money.

In 1942, 163,000 people died of cancer. To combat the disease the Cancer Society in its drive for funds succeeded in collecting approximately \$4,000,000 this year.

#### Survey by Institute

The American Institute of Public Opinion questioned men and women from coast to coast on the following issues:

Should Congress pass a law which would provide \$200,000,000 for the study and treatment of cancer in this country?

The vote:

Yes .....	81%
No .....	10%
No Opinion .....	9%

Would you be willing to pay more taxes to provide this money?

The vote:

Yes .....	75%
No .....	20%
No Opinion .....	5%

—George Gallup in *Los Angeles Times*, July 21.

### Cancer Statistics

Harry S. Mustard, M.D., in a recent article stated:

By "Cancer" the public refers to all malignant tumors. Cancer is a public health responsibility because it affects relatively large numbers of people, because its frequency as a cause of death appears to be on the increase, because in some forms, in certain locations, and in particular stages, fatal extension is preventable, and because systematized social action seems necessary in approach to the problem.

One may obtain an idea of the trend of mortality in cancer and other malignant tumors by comparing death rates from these conditions, and from tuberculosis, over a period of years. In 1900 the tuberculosis death rate was more than three times that of cancer. The one has fallen and the other risen, so that the malignant disease death rate is now nearly three times as great as the death rate from tuberculosis.

Of the 158,335 deaths caused by cancer and other malignant tumors in the Registration Area of the United States in 1940, the digestive tract was the seat of the disease in about 50 per cent. In 10.6 per cent it was cancer of the uterus; cancer of the breast in 9.8 per cent. Cancer of the buccal cavity and pharynx was the seat of 3.2 per cent of all cancer deaths. Females are more frequently affected by malignant disease than are males. Of the 158,335 deaths from that cause in the U. S. Registration Area, in 1940, 75,406 were in males, and 82,929 in females. This excess proportion of deaths in females is largely incident to the greater frequency of carcinoma of the breast in that sex, and to the frequency of carcinoma

of the uterus. Speaking in round numbers, it may be said that in the U. S. Registration Area in 1940, more than 15,000 females died of carcinoma of the breast, and less than 200 males. There were nearly 17,000 deaths from carcinoma of the uterus. Carcinoma of the buccal cavity, pharynx, and stomach are seen more frequently in males, and there were more than 12,000 deaths from carcinoma of the prostate and of the bladder in males in 1940.

The mortality rates in 1940, for cancer and other malignant tumors, are found to be 78.4 deaths per 100,000 population for Negroes, and 125 per 100,000 population for whites.

The Objectives in Cancer Control Programs are:

1. To teach the public to apply for early medical attention.
2. To influence the development of special cancer clinics, private and public, where there are ample provisions for diagnosis and treatment.
3. To influence the medical profession to make use of these special clinics in both diagnosis and treatment.
4. To encourage government and philanthropic support of institutes for cancer research, and to emphasize the need of experts in research.

## COMMITTEE ON INDUSTRIAL PRACTICE

### Inyo-Mono County Medical Society Acts on Revised Compensation Fee Schedule

On July 1, 1944, the Inyo-Mono County Medical Society adopted the fee schedule for Physicians and Surgeons for services rendered under Workmen's Compensation and Safety Laws, which schedule was presented to the Industrial Accident Commission of the State of California on December 30, 1942.

The following letter was sent to insurance companies:  
 Bishop, California, May 14, 1945.

Gentlemen:

On July 1, 1944, the members of this society put into effect a new fee schedule for all industrial accident cases. This is the fee schedule compiled by the C.M.A. in 1942. A printed copy was mailed to your office in May of 1942.

Enclosed is a compilation of the payments received by the physicians of this area from various insurance carriers since that time.

You will note that some of these carriers have paid all accounts in full. Your company has not.

The State Compensation Insurance Fund has paid over 57 per cent of its cases in full; in 23 per cent of cases it has underpaid; and in 20 per cent of its cases it has paid in excess of our bills as rendered.

Other companies, including your own, have a similar record, varying in percentages.

Therefore, at the April meeting of this medical society it was unanimously voted to notify all companies which have not been paying our bills in full, according to our fee schedule, that after June 1, 1945, all industrial accident cases will be accepted only at our schedule, and no other. The secretary of this society will expect to receive from you, previous to June 1, a written acceptance of this condition.

If such a letter is not on file in this office by June 1, 1945, it will be necessary to get telephone authorization from your office for care at our rates, in each case. Should this not be forthcoming, it will be necessary to hold the employer responsible for the costs of care. We sincerely hope you will not make this action necessary.

Yours sincerely,

WALTER WILSON, M.D.,

Secretary,

Inyo-Mono County Medical Society.



	<i>Total Cases</i>	<i>In Full</i>	<i>Under- Paid</i>	<i>Over- Paid</i>	<i>Pending</i>
Calif. Comp. Ins. Co.....	93	61	32	0	0
State Comp. Ins. Fund.....	77	44	18	15	0
Ind. Indemnity Exchange.....	39	20	17	2	0
Colonial Ins. Company.....	21	10	10	0	1
Nat. Automobile Ins. Co.....	20	6	13	0	1
Maryland Casualty .....	9	7	0	1	1
Calif. Electric Co.....	10	8	0	0	2
Travelers Ins. Co.....	7	1	6	0	0
Pacific Employers Ins. Co.....	5	1	4	0	0
Standard Accident Ins. Co.....	5	5	0	0	0
Hartford Ins. Co.....	1	0	1	0	0
Employers Mutual Liability Company of Wisconsin.....	1	1	0	0	0
Nevada Industrial .....	1	1	0	0	0
Fireman's Fund Indemnity.....	3	1	1	0	1
Great American Co.....	3	2	1	0	0
City of Los Angeles.....	All cases in full				

Above are listed under each insurance company a compendium of industrial accident cases treated by the physicians of the Inyo-Mono County Medical Society from July, 1944, to May 1, 1945, under the new fee schedule. The total cases are given, number paid in full, underpaid, overpaid, a few cases payment pending.

#### Health Hazards Improved in Certain Los Angeles Plants

Study of Los Angeles electroplating plants, initiated by the Division of Industrial Hygiene in April, has shown such remarkable improvement in conditions since a similar survey conducted in 1941, that the industry was given commendation for interest and cooperation in improving working conditions.

The earlier study had revealed at least one industrial health hazard in every plant, involving dusts, mists, gases, vapors, illumination, or sanitation. In the 15 plants visited by the end of April in the current study, these hazards had been eliminated. Chromium plating, cyanide plating, and trichlorethylene degreasing tanks were found to be equipped with adequate slot exhaust ventilation; all bright dip tanks were either exhaust ventilated or isolated in open sheds; buffing and polishing wheels were provided with exhaust ventilation; the majority of washing and toilet rooms met minimum sanitation requirements; and fluorescent fixtures had replaced many of the bare, unshaded incandescent bulbs.

#### California to Study Tunnel Hazards

Exposure of railroad engineers and firemen to heat, gas, and fumes while traveling through tunnels is being investigated by the Bureau of Adult Health of the State of California Department of Public Health, in a cooperative study with the U. S. Bureau of Mines, the State Railroad Commission, and the State Industrial Accident Commission.

Because of the difficulty of obtaining reliable air samples and temperature measurements during the brief run of a locomotive through a tunnel, special methods have had to be devised for the study. A mobile chemical laboratory is to be shifted from point to point for the investigation. Gas samples collected by engineers in the locomotive cabs, and in the tunnels after trains have passed through, are to be analyzed immediately by the chemist.

Tests are to be made in 21 tunnels throughout the State, many of them having steep grades which make the heat, gas, and fume conditions complained of by trainmen more severe. For steam locomotives, measurements will include air temperature, relative humidity, air veloc-

ity, carbon dioxide and oxygen, carbon monoxide, sulfur dioxide, and smoke. In the case of diesel engines, temperature measurements will be omitted, but tests of nitrogen oxides will be made.

#### Federal Safety Council Hears Health Plan

Accidents to Federal workers in 1944 cost the government approximately \$18,000,000 in direct compensation. It was revealed by the U. S. Employees' Compensation Commission at the quarterly meeting of the Federal Interdepartmental Safety Council held in Washington June 8. Eight government employees were injured by unsafe handling of materials to every one hurt by explosions, fire, electrical burns, or other causes.

Necessity for a health program in the Federal service was explained by Dr. John W. Cronin, Chief of the U. S. Public Health Service Dispensary, who outlined a plan for such a program. Included in the health services recommended would be a preplacement physical and mental examination of every employee, with periodic re-examination. He proposed that a medical dispensary should be established in every Federal agency of sufficient size, where treatment could be given on the job for minor illnesses and injuries, and through which a broad program of health education could be carried on. Workers suffering from serious or chronic illnesses would be referred to their private physicians.

Accidental injuries showed a considerable decrease in 1944 from the level of previous years, the detailed report submitted to the Council by the U. S. Employees' Compensation Commission indicated. The average severity of injuries also was reduced.

#### Rehabilitation of Handicapped Civilians Promoted

Attention of the nation was focussed upon the necessity of providing rehabilitation services for handicapped civilians as well as war veterans, with President Truman's proclamation designating June 2-9 as National Rehabilitation Week.

Employability of persons in the working age range who are handicapped by accident, disease, or congenital conditions is the goal of the program carried on by the Office of Vocational Rehabilitation, Federal Security Agency, in cooperation with the States.

About 1,500,000 men and women of working age are prevented from earning a normal livelihood by physical or mental handicaps, it was pointed out, and more are added by the annual toll of accidents and illness.

The Constitution, in all its provisions, looks to an indestructible Union composed of indestructible States.

—Salmon P. Chase, *Decision*, in *Texas v. White*, 7 Wallace, 725.

# CALIFORNIA PHYSICIANS' SERVICE†

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\* \* \*

## Executive Staff

W. M. Bowman, Executive Director  
 A. E. Larsen, M.D., Medical Director  
 W. H. Gardenier, M.D., Assistant Medical Director

We wish to give the California Medical Association the following progress report of California Physicians' Service from July, 1944, to July, 1945. This is not a detailed report, and the figures used are approximate. Listed below are the principal departments with a brief summary of their activities:

## Beneficiary Membership

### MEMBERSHIP

	July, 1944	July, 1945
Commercial Program .....	78,843	149,000
Housing Program.....	17,006	11,500
Rural Program .....	1,184	2,000

### INCOME

Commercial Program (monthly income)...	\$85,000	\$168,000
Housing Program (monthly income)...	27,381	17,300
Rural Program (monthly income).....	2,849	3,070

## BENEFICIARY MEMBERSHIP

In the Commercial Program, our membership as well as the dues income has almost doubled during the last 12 months.

## PROFESSIONAL RELATIONS

(a) In September, 1944, this Department was established in order to improve our relationship with professional members. Four persons were employed and trained to contact the doctors, their nurses, and secretaries. A C.P.S. "Information Kit" for doctors offices was prepared which contained a summary of benefits for beneficiary members, a facsimile of membership cards, fee schedule, and other pertinent material. To date more than 2,000 doctors offices have been visited.

(b) We have supplied a C.P.S. speaker for many County Medical Society meetings. Medical Staff meetings in a number of the Metropolitan hospitals have been attended by our speakers.

(c) Articles are written and submitted to various County Medical Societies who issue monthly bulletins.

(d) Active drives for new professional members are handled by our Professional Relations Department. Over 300 new doctors have joined during the last year. To date C.P.S. has 5,600 professional members. We have found that this department is doing a great deal to perfect our working relationship with professional members.

## PUBLIC RELATIONS

This Department was organized in March, 1945, and

has four trained speakers. Its purpose is to inform the business men of the State on Voluntary Health coverage as offered by the doctors and hospitals. To date 97 talks have been given to service groups such as, Rotary, Kiwanis, Lions, Chamber of Commerce, Optimists, and various women's clubs. Approximately 3,840 business men and women have heard our speakers. Endorsements from the Chamber of Commerce, Merchants and Manufacturers, Downtown Business Men's Associations and other such organizations have been due to the efforts of this department. The primary functions of our Public Relations is to produce leads for the Sales Department. The speakers reports show that only 5 per cent of the audiences have ever heard of the doctors and hospital service. Many new groups are now being written by our Sales Department through the work of Public Relations.

## HOUSING PROGRAM

The C.P.S. War Housing projects are disintegrating. As you know these were to be temporary, and it seems that their purpose is almost at an end. We are closing the two medical centers in Long Beach, namely: Wilmington Hall and Channel Heights on July 15 and August 1, 1945. This leaves only two C.P.S. Housing Projects in the State, Vallejo and Marin City. Our project in Marin City is rapidly being taken over by evacuees from the Orient and Army and Navy personnel. It cannot last very long. Vallejo is still an acute area, and the Housing Project Medical Centers will remain for some time due to a request by the Solano County Medical Society.

## FARM SECURITY PROGRAM

C.P.S. has rendered care to some 2,000 low income farm families. This program was carried on in conjunction with the Farm Security Administration. The doctors were paid a unit value of \$1.50. We are now negotiating with the California State Grange, which has a membership of about 25,000 farmers—with dependents this represents about 80,000 persons. Our Two-visit Deductible and Surgical service is being offered. If the Grange or any other large farm group accept our service we will then liquidate the old Farm Security Plan, and place all coverage under our Commercial Program.

## RATE INCREASE

C.P.S. has had a long hard struggle in returning a reasonable fee to its professional members. Much ill-will has been caused because of a low unit value. From an all-time low unit of \$1.20 three years ago, C.P.S. has gradually corrected certain functions, and during the last 15 months has paid a unit value of \$2.25, which is 90 per cent of the par, \$2.50. In order that we could reach par and at the same time broaden out benefits to beneficiary members, the Trustees voted a rate increase of approximately 30 per cent to beneficiary members the first part of December, 1944. Due to objections by the Hospital Association this was held up until April of 1945. However, the rate of increase is 95 per cent completed, and we have lost less than ¼ of 1 per cent membership due to this rate increase.

## REVISION OF ADMINISTRATION

Since the May meeting of the House of Delegates C.P.S. has been undergoing certain changes in its administration. New personnel for key positions are being brought in, two from out of the State, and several from within the State. Some of our older personnel are being placed in positions for which they are better fitted. Office procedures and functions are being revised and streamlined.

This report lists most of the principle functions of C.P.S. Although some of these have been in operation

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization through W. M. Bowman, Executive Director.



only a short time the results have convinced me that they will add to the growth and efficiency of C.P.S. I am not over-optimistic in predicting that C.P.S. will double and probably triple its present beneficiary membership during the next 12 to 14 months. Responsibility for much of our success and development continues to rest with our professional members, for it is they who are rendering the service.

**California Coördinating Committee—Re: C.P.S.**

(COPY)

WAR MANPOWER COMMISSION  
PROCUREMENT AND ASSIGNMENT SERVICE  
For Physicians

San Francisco, July 5, 1945.

Philip K. Gilman, M.D.,  
Chairman of the Council,  
California Medical Association.

Dear Doctor Gilman:

I am enclosing herewith a copy of a letter to the Board of Trustees of the California Physicians' Service which I was directed to write by the members of the Coördinating Committee, Procurement and Assignment Service, at their last meeting. I realize that without the backing of the Executive Committee and the Council of the California Medical Association that the California Physicians' Service would have been unable to carry on these programs as it has. It was, therefore, the consensus of the Coördinating Committee that I should again express its appreciation to the Council of the C.M.A. for its backing and coöperation during this emergency.

With my kindest regards, I remain,

Sincerely yours,

(Signed) HAROLD A. FLETCHER, M.D.,  
*California State Chairman for Physicians'  
Procurement and Assignment Service.*

\* \* \*

(COPY)

WAR MANPOWER COMMISSION  
PROCUREMENT AND ASSIGNMENT SERVICE  
For Physicians

San Francisco, July 5, 1945.

Lowell Goin, M.D.,  
Chairman of the Board of Trustees,  
California Physicians' Service,  
1930 Wilshire Boulevard,  
Los Angeles, California  
and

Chester L. Cooley, M.D.,  
Secretary, Board of Trustees,  
California Physicians' Service,  
490 Post Street,  
San Francisco, California.

Gentlemen:

At the regular meeting of the Coördinating Committee of the Procurement and Assignment Service of June 5, 1945, I am instructed to write a letter to the Board of Trustees of the California Physicians' Service expressing the appreciation of the Coördinating Committee of Procurement and Assignment Service for the real aid and contribution to the war effort which has been made by the California Physicians' Service. With the tremendous needs of the military forces for medical personnel and with the tremendous expansion in population in certain

localities in California antedating and following the Pearl Harbor attack, there were many problems of medical care which the Procurement and Assignment Service was called upon to solve. One of the greatest problems, of course, was medical coverage in many of the housing projects in critical areas where the population mushroomed to a tremendous size without any previously worked out plan for medical care. The Procurement and Assignment Service was faced with several alternatives at different times, many of which would have been dangerous to the future of the medical profession.

California was fortunate in having an organization in the California Physicians' Service, backed by the medical profession, which could, during the emergency, expand its activities to cover these emergency needs. Had not the California Physicians' Service willingly and patriotically coöperated with the war effort, the critical needs would not have been met; or if they had been met, it would have been through means which would probably have jeopardized the future of many physicians patriotically serving their country in the military forces, and would have undoubtedly undermined the freedom of the practice of medicine in California. Although the California Physicians' Service was not set up to undertake this type of medical coverage, with the backing of the California Medical Association it was able to meet the needs when called upon to do so. The Coördinating Committee has appreciated the coöperation of both the California Medical Association and the California Physicians' Service which it has had at all times. The work of the California Physicians' Service in meeting emergency needs in housing projects and expansion areas has been outstanding and has entailed a tremendous amount of organizational and executive work. At times it has had to fight organized resistance to it on the part of extreme leftish organizations as well as, unfortunately at times, resistance on the part of the medical profession. It is to be noted, however, that in practically all those cases where the medical profession coöperated the program in the housing projects has been successful both from the standpoint of the patient as well as the local physician.

It is the opinion of the Coördinating Committee that, in spite of many complicated and varying difficulties under which it had to work, the California Physicians' Service has contributed an outstanding service to the war effort in California.

Yours very truly,

(Signed) HAROLD A. FLETCHER,  
*Chairman, Coördinating Committee  
on Medical Care,  
Procurement and Assignment Service.*

P.S.—For your information, I am appending a full list of the membership of the Coördinating Committee of Procurement and Assignment Service.\*

H.A.F.

\* \* \*

*Membership of the Coördinating Committee of  
Procurement and Assignment Service*

Harold A. Fletcher, M.D., Chairman, Room 1331, 450 Sutter Street, San Francisco 8, California.

George E. Ebright, M.D., Vice-Chairman, 384 Post Street, San Francisco, California.

Mr. John Hutton, Secretary, Room 2004, 450 Sutter Street, San Francisco 8, California.

(\*Ed. Note.—In the Harbor Area of Los Angeles, C.P.S. rendered notable service in housing projects at Wilmington, Banning Homes and Channel Heights. So also in housing projects in the San Francisco Bay area. At the Richmond Center, California Medical Association coöperated with C.P.S. by subsidizing the medical center to a total of \$6,266.30, as noted in June CALIFORNIA AND WESTERN MEDICINE, on page 346, under item 8.)

*Colonel W. T. Harrison*, Regional Medical Director, U. S. Public Health Service, Appraisers' Building, San Francisco, California.

*Wilton Halverson, M.D.*, Director, State Dept. of Public Health, 760 Market Street, San Francisco, California.

*Morton Gibbons, Sr., M.D.*, Chief Emergency Medical Service, State War Council, 411 Phelan Building, 760 Market Street, San Francisco, California.

*Ernest Stoman, D.D.S.*, Dental Chairman, Ninth Corps Area, Procurement and Assignment Service, 344 14th Street, San Francisco, California.

*John W. Leggett, D.D.S.*, California State Chairman for Dentists for Northern California, 490 Post Street, San Francisco, California.

*Albert E. Larsen, M.D.*, Medical Director, California Physicians' Service, 153 Kearny Street, San Francisco, California.

*Karl L. Schaupp, M.D.*, Ninth Corps Area Chairman, Procurement and Assignment Service, 490 Post Street, San Francisco, California.

*Anthony J. J. Rourke, M.D.*, Superintendent, Stanford Hospital, Clay and Webster Streets, San Francisco, California.

*L. R. Chandler, M.D.*, Dean, Stanford University Medical School, Clay and Webster Streets, San Francisco, California.

*William P. Shepard, M.D.*, Medical Director, Metropolitan Life Insurance Company, 600 Stockton Street, San Francisco, California.

*Mr. Thomas Clark*, Executive Officer, Association of California and Western Hospitals, 1182 Market Street, San Francisco, California.

*Miss Marian Alford, R.N.*, Chairman, Procurement and Assignment Service for Nurses, 26 O'Farrell Street, San Francisco, California.

*Mrs. M. E. Schmidt, R.N.*, Nurse Deputy to Chief of Emergency Medical Service, State War Council, 411 Phelan Building, 760 Market Street, San Francisco, California.

## COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

### Commonwealth Club of San Francisco Votes on Sickness Insurance Plans

By a two to one vote, Commonwealth Club of California members have indorsed voluntary health insurance, a tally revealed in July. Members expressed their opposition to compulsory plans in another ballot, however, it was announced.

Voting followed study of the question by the club's public health section.

Club officers said that, while opposing compulsion, the majority held that if a compulsory plan were adopted, the "free system" of paying doctor bills would be preferable to the "per capita system." The majority also held that if a compulsory plan were adopted, Governor Warren's bill in the recent legislative session would be preferable to the C.I.O. bill.

Members favored State regulation of voluntary health plans as to character and solvency, premiums charged and extent and quality of services. They opposed State financial assistance to voluntary plans, but favored educational assistance and legal status clarification.

Complete results follow:

I. (a) Should California encourage voluntary enrollment of its citizens in various private prepayment health plans? (Yes 859, No 248)  
(b) Should it be done now? (Yes 776, No 175)

II. (a) Should California establish some compulsory prepayment health insurance system? (Yes 451, No 741)  
(b) Should it be done now? (Yes 406, No 549)

III. If, regardless of your opinion above, some such system is to be established, which is preferable:

(a) Voluntary? (833) OR  
(b) Compulsory? (403)

IV. If any compulsory system is established which of the following general proposals should be adopted:

(a) Adoption of a compulsory insurance plan in which citizens who are employees will prepay for doctor, surgical, and hospital services through automatic deductions from salaries or wages as a payroll tax? (907)

(b) Direct public support of all health services through other taxation? (241)

V. If "I" above were adopted should the State assume regulatory powers over private prepayment health plans as to:

(a) Character and solvency of any organization offering a prepayment health service? (Yes 1072, No 117)

(b) Premiums charged? (Yes 866, No 301)

(c) Extent and quality of services to be rendered? (Yes 884, No 280)

VI. If "I" above were adopted, should the State encourage voluntary prepayment health plans by:

(a) Rendering financial assistance? (Yes 336, No 788)

(b) Clarifying legal status? (Yes 921, No 197)

(c) Giving educational assistance? (Yes 918, No 224)

VII. If "II" above were adopted, should the physician be paid:

(a) Per unit of services he renders (i.e., "fee system")? (906)

(b) Per patient enrolled with him (i.e., "capitation system")? (240)

VIII. If "II" were adopted, should provision be made in it for health service for the indigent? (Yes 853, No 279)

IX. If "IV-a" were to be adopted, should the cost be borne:

(a) By payments entirely from the employee? (359)

(b) By joint payments from both employee and the employer? (329)

(c) By joint payments from the employee, the employer, and the State? (480)

X. If "IV-a" above were adopted

(a) Should the plan require an employee to pay in full or in part for the first visit to a physician in any illness? (Yes 85, No 340)

(b) Should limitations be placed upon

(1) Length of time during which a physician's service would be available for an illness? (Yes 415, No 629)

(2) Length of hospitalization for an illness? (Yes 429, No 558)

(c) Should the employee be required to pay the first \$50 of bills for illnesses in any one year and the Fund pay all further medical and hospital bills? (Yes 502, No 512)

XI. If compulsory health insurance is established, should the State encourage private groups to provide service under the Act? (Yes 808, No 205)

XII. Of following proposed plans recently before the Legislature, which do you consider satisfactory?

(a) Assembly bill 800 (Gov. Warren's bill)? (Yes 405, No 384\*)

(b) Assembly bill 449 (C.I.O. bill)? (Yes 141, No 504†)

(c) Assembly bill 1200 (Calif. Med. Assn. bill)? (Yes 403, No 370‡)

(d) Senate bill 219 (Farm Bureau bill)? (Yes 99, No 526§)

XIII. If either of the COMPULSORY health insurance proposals recently before the Legislature were to be adopted, would you prefer:

(a) Assembly bill 800 (Gov. Warren's bill)? (809)

(b) Assembly bill 449 (C.I.O. bill)? (124)

XIV. Do you favor a compulsory plan for hospital care alone? (Yes 182, No 890)

XV. Do you think the present Legislature should study the question of health measures through an interim committee until the next session? (Yes 814, No 270)

XVI. Should the present Legislature refer the general question of compulsory health insurance to a popular vote? (Yes 510, No 594)

\* 469 did not answer. † 613 did not answer. ‡ 485 did not answer. § 633 did not answer.

Why forego the advantages of so peculiar a situation? Why quit our own to stand upon foreign ground? Why, by interweaving our destiny with that of any part of Europe, entangle our peace and prosperity in the toils of European ambition, rivalry, interest, humor or caprice?

—George Washington, *Farewell Address*, 17 September, 1796.



# MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

## NEWS

### Coming Meetings†

**California Medical Association.** Session will convene in Los Angeles. Dates of the seventy-fifth annual session, to be held in 1946, will be announced later.

**American Medical Association.** The 1945 Session, previously scheduled for Philadelphia, will not be held.

### The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments or principles included in the A.M.A. platform appear in *CALIFORNIA AND WESTERN MEDICINE* for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576. See also C. AND W. M. for August, 1945, pp. 61-62.)

### Medical Broadcasts\*

**The Los Angeles County Medical Association:**

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a.m., under the title, "Your Doctor and You."

In August, KFAC will present these broadcasts on the following Saturdays: August 4, 11, 18, and 25.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

\* County societies giving medical broadcasts are requested to send information as soon as arranged.

### Pharmacological Items of Potential Interest to Clinicians\*

1. *Notes on Books:* In addition to 'Tom Keys' fine and finely illustrated account of *The History of Surgical Anesthesia*, the volume contains an excellent essay by Noel Gillespie pointed to the future, and a neat bibliographical account of Morton items by John Fulton (Schuman's, 20 E. 70, N. Y. 21, 1945, \$6). D. T. Starnes edition of W. Clowes' *Books of Medical Observations* (1596) is interesting but poorly lithoprinted (Scholars' Facsimiles and Reprints, N. Y., 1945). Another well illustrated pertinent survey is N. Taylor's *Cinchona in Java* (87 pp., Greenberg, N. Y., 1945, \$2.50). J. Wiley, 440 4th Ave., N. Y. 16, offers R. S. Bates' *Scientific Societies in the United States* at \$3.50 and A. L. and K. B. Winton's *Analysis of Foods* at \$12. W. B. Cannon stimulatingly discusses *The Way of an Investigator: A Scientist's Experiences in Medical Research*, in summing up his fruitful years (W. W. Norton, 70 5th Ave., N. Y. 11, 229 pp., 1945, \$3). A Kardiner studies *The Individual and His Society: The Psychodynamics of Primitive Social Organization* (Columbia Univ. Press, 305 pp., 1945, \$4). Important for book publication is R. J. Henry's *Mode of Action of Sulfonamides*, a fine critical review with 698 references (Publ. Josiah Macy Jr. Foundation, Review Series, 2:1-285, 1944). Note *Report of Survey of Medical Records Created by Federal Government* (National Research Council, 180 pp., Washington, 1945).

2. *Notes on Symposia:* Otherwise helpful symposium on sympathomimetic agents held by American Chemical Society (*Ind. Eng. Chem.*, 37:116-151, 1945) is unbalanced by failure to include summary by Gordon Alles. R. J. Williams & Co. issue interesting series of Cancer Studies (*Univ. Texas Publ.*, No. 4507, Austin, 1945) with articles on virus-like tumor agent by A. Taylor and tumor effects on Hb by R. E. Hungate. R. A. Willis offers stimulating review of recent advances in experimental production of tumors (*Med. J. Austral.*, 1:361, Apr. 14, 1945). About 600 reports in 1945 Federation Proceedings ranging from H. W. Ades on the corpus callosum to C. Weiss and N. Halliday on tuberculo-carbohydrates and phosphatides (*Fed. Proc.*, 4:1-166, 1945), of which fair share is Blakins!

3. *Summer Simmerings:* H. A. Howe tells why it doesn't help to be afraid of polio in an excellent summary of current thought (*Harper's*, 190:646, June, 1945). D. Ludwig offers a pertinent and well documented review on effects of atmospheric humidity on animal life (*Physiol. Zool.*, 18:103-135, 1945). T. F. Rose discusses urinary colic due to crystalluria and calculi in hot humid climates (*Med. J. Austral.*, 1:558, June 2, 1945). C. P. Mathe neatly reviews differential diagnosis and treatment of anuria (*Urol. Cutan. Rev.*, 49:223, 1945). R. M. Stecher makes a pleasant plea for more light (*Bull. Med. Lib. Assn.*, 33:220, 1945).

4. *Notes on Body Composition:* H. H. Mitchell & Co. discuss chemical composition of adult human body with reference to calcium and its bearing on biochemistry of growth, finding subjects vary by 25%, and that much calcium is lost by sweating (*J. Biol. Chem.*, 158:625, 1945). E. N. Rathbun, N. Pace & Co. find female body

\* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacological Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

averages 4.7% more fat than male; water averages 72.4% fat free body mass with standard deviation of 2.1%; chemically combined nitrogen averages 3.5% lean body mass, standard deviation 0.27%; lean body mass relatively constant, with fat as a diluent (*Ibid.*, p. 667-691). L. Arnold & Co. report general health and mental performance, but not physical prowess, is superior in good eater as compared with bad eaters in 7 year olds (*S. Afr. J. Med. Sci.*, 10:9, 1945).

5. *Notes*: J. K. W. Ferguson and L. P. Dugal note RQ of expired air may be used to calculate relations between CO<sub>2</sub> and O<sub>2</sub> tensions in alveolar air (*Canad. J. Res. Med. Sci.*, 23:32, 1945). H. Koteen gives encouraging survey of lymphogranuloma venereum (*Med.*, 24:1, 1945). F. C. Warring proposes estimation of ratio of maximum lung ventilation to walking ventilation as a guide to thorocoplasty (*Amer. Rev. Tb.*, 51:432, 1945). A. Lacassagne & Co. of reviving Paris find that application of weak carcinogenic hydrocarbons inhibits subsequent action of strong carcinogens of like molecular structure, by blocking (*Brit. J. Exp. Path.*, 26:5, 1945). A. K. James recommends 2 mgm carbaminoylcholine thrice or more daily to reduce migraine attacks (*Brit. Med. J.*, 1:663, May 12, 1945). E. J. Boell reports that nerve degeneration results in marked reduction in choline esterase activity (*J. Cell. Comp. Physiol.*, 25:75, 1945). H. Hartridge discusses change from trichromatic to dichromatic vision in human retina (*Nature*, 155:657, June 2, 1945).

**Dr. Robert Peers, Colfax Mayor for 23 Years, Resigns.**—Colfax (Placer Co.), July 11.—After serving as mayor of this city for more than 23 years, Dr. Robert A. Peers last night resigned from the city council. . . .

Dr. Peers first was elected to the city council in 1921 and in 1922 he was elected mayor, a post to which he has been reelected each successive two years.

The local physician, a former president of the California Medical Association, recently was elected a member of the board of trustees of the American Medical Association. . . .—*Sacramento Bee*, July 11.

**Unusual Newspaper Advertisement.**—One of the San Francisco pharmacies (Bowerman's) in a recent 4 by 4 inch display advertisement having the caption *Don't Neglect Your Doctor's Bill* gives additional advice as follows:

"It is your doctor who has studied for years to preserve life and maintain health. Working constantly, he is on call 24 hours a day. So when it is time to pay the bills, don't forget the man who does so much for you—your doctor."

**On Prevention of Colds.**—Everyone can achieve some immunity from acute respiratory infections such as colds; most people need never have a cold again, according to Dr. Marshall C. Cheney, associate physician, Student Health Service, on the Berkeley campus of the University of California. Summing up data secured from observations of eighteen years on more than 20,000 university students, Dr. Cheney says that cold vaccine plus proper hygiene and other therapeutic measures will protect all except those unfortunate individuals who have inherited extremely poor automatic defense. . . .—*University of California Clip Sheet*, July 23.

**The Eye-Bank for Sight Restoration, Inc.**—Teaching and research fellowships to extend the knowledge and skill required for the delicate operation which restores sight to a blind person with a corneal defect

through the grafting of healthy corneal tissue will be established in leading medical schools throughout the country by The Eye-Bank for Sight Restoration, Inc., 210 East 64th Street, New York City, it was recently disclosed by Mrs. Henry Breckinridge, executive director. To carry on this program of education and research, as well as its other activities, The Eye-Bank will undertake to raise \$1,000,000, Mrs. Breckinridge announced at national headquarters.

An initial grant of \$25,000 has been made by the Milbank Memorial Fund to enable The Eye-Bank to function pending the time when the importance of the undertaking may gain recognition and widespread support. It is hoped that financial support will be forthcoming from the general public in sums of any amount.

In a statement accompanying Mrs. Breckinridge's announcement, Albert G. Milbank, president of the Milbank Memorial Fund and chairman of the Advisory Council of The Eye-Bank, expressed "the hope and expectation that The Eye-Bank for Sight Restoration, Inc., will make important contributions to public health by advancing our knowledge of the pathology of the eye, thus making the prevention of eye diseases more effective, by improving or restoring the sight of persons who are handicapped by corneal opacities, and by its educational procedures which should arouse interest in sight conservation among physicians, specialists and the public."

**Red Cross Announces Civilian Blood Donor Recruiting Program.**—American Red Cross chapters throughout the nation will be permitted to recruit blood donors for civilians under a program announced by National Chairman Basil O'Connor. Under this project any Red Cross chapter may take part in the operation of a donor center for civilians sponsored by a recognized medical or health agency. The blood collected and the blood derivatives produced will be made available without cost to physicians, hospitals, clinics and patients.

This civilian program is entirely separate from the Blood Donor Service operated by the American Red Cross for the Armed Forces, and chapters in the eleven metropolitan centers where the Red Cross is now recruiting donors for the Army and Navy will not participate in it. These are: Los Angeles, San Francisco, Oakland, Portland, Ore., San Diego, Chicago, New York, Brooklyn, Boston, Philadelphia, and Washington.

The formal announcement of the new program stated in part:

"The need for provision of blood and such derivatives as blood plasma and immune (measles) globulin in amounts sufficient to meet civilian needs is very real and great. Their unique and vital place in medical practice, so strongly emphasized by the war, is becoming widely recognized by medical and health agencies throughout the country, and many of these agencies already have developed or are planning programs to insure the provision of blood and its derivatives to meet civilian needs. The American Red Cross is now preparing to help its chapters to assist in this essential service."

Assistance in establishing standards and conducting a civilian program will be made available to chapters through the five Red Cross area offices. The new project will be supervised by an advisory committee of specialists to be appointed.\*

**The National Society for the Prevention of Blindness, Inc.**—The Leslie Dana Gold Medal, awarded annually for outstanding achievements in the prevention

(\* Ed. Note.—For action of C.M.A. Council concerning a State Blood Bank in California, see CALIFORNIA AND WESTERN MEDICINE for June, on page 345, item 6.)



of blindness and the conservation of vision, will be presented this year to Dr. William Zentmayer of Philadelphia, it is announced by the National Society for the Prevention of Blindness.

This highly prized token of recognition in the field of public health is given upon the recommendation of the Association for Research in Ophthalmology.

Despite his 80 years, Dr. Zentmayer is in active practice as an ophthalmologist. He is Professor Emeritus of Diseases of the Eye, Graduate School of Medicine, University of Pennsylvania.

The conditions of the Leslie Dana Gold Medal award set forth that it is to be made for "long meritorious service in the conservation of vision in the prevention and cure of diseases dangerous to eyesight; research and instruction in ophthalmology and allied subjects; social service for the control of eye diseases; and special discoveries in the domain of general science or medicine of exceptional importance in conservation of vision."

**Immune Serum Globulin for the Prophylaxis and Modification of Measles.**—The report received from health officers and physicians through July 15, 1945, by the California State Department of Public Health on the use of immune serum globulin for the prophylaxis and modification of measles showed the following results:

Total reports received .....	448
No measles .....	304 (68%)
Measles .....	142 (32%)
Not stated .....	2

Of the 142 recipients who subsequently developed measles, 101 were classified as mild cases, 33 as moderately severe and only 8 as severe.

The reports also showed that in 330 cases or 74 per cent of the total, the immune serum globulin was administered within six days after the date of exposure.

This product may be ordered from: Bureau of Acute Communicable Diseases, California State Department of Public Health, 1122 Phelan Bldg., 760 Market St., San Francisco 2, California.

**Press Clippings.**—Some news items from the daily press on matters related to medical practice follow:

#### Physicians

It is a reasonable thought that reduction in the size of the army after the victory in Europe should free some doctors to return to civilian practice where there is a great shortage. However, this is not a matter for curb-stone opinion. A Senate subcommittee went to work yesterday on the only line that can develop the facts, an investigation. The Army may not like to let go of any of its doctors, but the Senate has means to find out whether it still needs all those in uniform or could spare some without harm. As to the present scarcity of physicians in many communities there is no question.

This is a matter on which, if the Senate finds good reason, it may be able to do something promptly. The question of an adequate number of physicians for civilian needs in the future, which the subcommittee also proposes to look into, is not subject to swift action. Classes in medical schools have fallen off markedly, due to the draft. These years lost in the training of doctors are gone and cannot be made up by short cuts if standards are to be maintained. To make them good eventually may need some special encouragement of young men to undertake the arduous course necessary to prepare for the practice of medicine.—Editorial in *San Francisco Chronicle*, July 12.

#### Rupert Hughes Address—On "Cradle to Grave" Proponents

On June 16, 1945, the National Broadcasting Company presented Rupert Hughes . . . soldier, novelist, historian and humorist. Some excerpts from his address follow:

We are indeed fearfully and wonderfully made; and we live in a fearful and wonderful world. The cosmic rays that pierce us with their subtle lightnings come from out-

side our sphere. The starlight that falls so gently upon our eyes may have come from some far star that died a hundred thousand years ago. Yet we shall never know it, for the last of its rays will not reach the earth for another fifty thousand years or more. . . .

The danger of life today—and a growing danger—is that in trying to make everybody on earth our neighbor and our responsibility, we shall have no neighbors at all and we shall become not helpers but horrible meddlers.

Today we are being hounded to death by professional lovers of all mankind, universal busybodies; who have taken the whole world as their nurseries.

They promise us "security from the cradle to the grave." But who wants such security as they could give from such people as they are? What we really want is security from the security-mongers.

But why guarantee us only security from the cradle to the grave. Why stop there? One of the most important things in life is selecting your grandfather and mother. Most people put it off till too late. Will the government take care of that prenatal insurance—give us security before the cradle?

And why stop providing Security at the edge of the grave? That's when insecurity really begins. And that's too late, usually, to do much about it. . . .

Can anyone really look at the government today and the vast armies of municipal, state and federal employees and bosses who make up government, and trust either his immortal soul or his mortal body to it? Can anybody look at that mob and call it Papa or Mama and feel safe in its arms? . . .

These people who would save everybody on earth from any of the risks of life are not really the big-hearted lovers of mankind they pretend to be. They are simply the old familiar type of philanthropist who is far sighted that he ignores the suffering all about him.

I have encountered those very people before in appeals I have made for certain poor sufferers I wanted them to help relieve. They actually answered, "We are going to put an end to poverty. We are too busy to turn aside for mere individuals."

So these cosmic benefactors who would feed all the earth, keep everybody rich and happy, are overlooking and trampling the wretchedness all about them.

You may have noticed that they themselves draw salaries. They do not employ others. They build no factories. They sell their writings and their eloquences, but pay no wages, feed no hungry. Their very philanthropy is for sale. While shouting slogans about providing for everybody, they provide first for themselves. They make good money and win themselves glittering names as philanthropists. But they are apt to be hollow shells when it comes to helping their immediate neighbors and their own poor relations.

The worst of it is that by monopolizing the claims to kindness and hogging up all the credit for loving mankind, they make the rest of us look selfish and cruel. If you say you are afraid to try to feed all the world, they point you out as a brute without heart.

Their latest atrocity is the slogan: "Poverty anywhere is a Menace everywhere."

That is a slogan to put an end to all slogans. . . .

These omnibus philanthropists who would save all mankind or none, used to wait that more than one-third of our population is ill-fed, ill-housed, and ill-clothed. And they said that the government must try to feed everybody well, give everybody what he thinks is a proper house, and dress him and her to their liking.

Where will they stop? Everybody will make everybody rich.

Could anything be more insane? Nothing, except most of the other proposals of these fanatics who are running away with people's wits. What is it to be ill-fed? Most of us eat far too much. What is it to be ill-clothed? The sunlight is medicine. Ill-housed? He who has a mansion envies him who has a castle. . . .

#### Permanente Hospital Pharmaceutical House

Infra-red lamps have gone into pharmacy. They do highly important work in the plant of Royfield and Company, 4921 Broadway, Oakland, manufacturers of pharmaceutical products and distributors of hospital supplies and equipment. This firm's primary purpose is to furnish medicines and other essentials to the Permanente Hospitals established, at the suggestion of Henry J. Kaiser, in Oakland, Richmond, Fontana and Vancouver, Washington. But the establishment also serves other institutions and industries. It is owned by Dr. Sidney R. Garfield, director of the Permanente Hospitals, and his associate, Dr. C. C. Cutting. . . .—*San Francisco P. G. and E. Progress*, July.

### A Constructive Program

John H. Fitzgibbon, M.D., Portland, Oregon, chairman, Council on Medical Service and Public Relations of the American Medical Association, in a recent statement to physicians and secretaries of medical organizations in Chicago, said: "The health of the people of America is our direct concern and a responsibility that cannot be ignored. . . . As medical men and women, we possess information needed by lawmakers and other public servants. . . ."

"The objective of the American medical profession is 'availability of medical care of a high quality to every person in the United States.' . . ."

"Since 1875 . . . the American Medical Association has advocated 'the establishment of an agency of Federal government under which shall be coordinated and administered all medical and health functions of the Federal government, exclusive of those of the Army and Navy' . . ."

Other points emphasized by the Association and stressed by Dr. Fitzgibbon are:

(1) Extension of medical services to all the people and the utmost utilization of qualified medical and hospital facilities already established.

(2) Continued development of the private practice of medicine, subject to change necessary to maintain quality of medical services and increase their availability, including extension of voluntary hospital and medical insurance.

(3) Expansion of public health and medical services consistent with the American system of democracy.

(4) Allotment of public funds, on proof of need, to states when needed for prevention of disease, promotion of health and care of sick.

(5) That public health and medical service is primarily a local responsibility.

(6) The development of a mechanism for expansion of preventive medical services for the indigent, with local determination of needs and local control of administration.

Medical care can be made available to all through the cooperation of medical and allied professions, government, industry, labor and other interested groups, whereas continued attempts at compulsion will aggravate confusion and delay the earliest availability of a high quality of medical service to every person.—San Francisco *Western Underwriter*, May.

### Hope For Better Veteran Care

The reports by veterans organizations of poor conditions in various veterans hospitals throughout the Nation are shot with one significant undercurrent.

Bad food, low morale, inefficient operation, overcrowding, inadequate recreation, arrogant administration and medical and surgical lacks are charged in nearly all instances to the handicap of "bureaucratic control, official red tape and regimentation." To every family of a serviceman or veteran, that is vitally important information.

There is no lack of money, certainly for the imperative purpose of taking proper care of our veterans. With the appointment of General Bradley, veteran of this war, as head of the Veterans' Administration, there should be a complete housecleaning and thorough reorganization to assure every boy who risked his life for his country, the finest care available, unhampered by the red tape and regimentation that petty officialdom heaps so heavily on the shoulders of other wise competent veteran administrators and medical men.

"Veterans are thoroughly sick of those tactics when they get their discharge papers," declared Fred Kraft, San Diego Assemblyman, as the Legislature adjourned last week. "That is why we refused at this session to embroil the people in any compulsory plan of medical insurance. The story would be exactly the same—red tape, politics and regimentation—when a fellow really needs a competent doctor or a good rest!"

If we are not to deal shabbily with our fighting men, conditions in many of the veterans hospitals must certainly be improved. Only high type hospital personnel, relieved of some of the bureaucratic, paper-pushing chores that impede the job they really want to do, can help this Nation discharge its solemn obligations to its veteran sons.

The spring issues of Reader's Digest and Cosmopolitan (one a reprint) were shocking in their illuminative information regarding hospitals under Veterans' Administration.

It's time for improvement—and hope is in General Bradley's appointment.—King City *Rustler-Herald*, June 21.

### Forty San Francisco Doctors Form Guild

Approximately forty San Francisco physicians and surgeons have formed a guild to serve as a collective bargaining

agency in what is believed to be the first union of doctors in the United States, it was learned today.

The physicians, all on the staff of the Southern Pacific Hospital, have elected Dr. James Guilfoil president of the guild.

"The purpose of the guild is to provide a collective bargaining agency under the provisions of the Wagner act—to represent the doctors in matters of wages and hours, if, as and when necessary," a spokesman of the organization said.

The union, according to its members, did not grow out of any controversy with the labor-employer management of the S. P. Hospital, but is the result of several years' thinking. They described relations at the hospital as "harmonious."

The guild is not affiliated with the A.F.L., C.I.O. or any other labor organization.

Dues of Southern Pacific employees in the hospital association were increased, but spokesmen for the guild declared this was caused by increased costs and not because of the doctors union.

In addition to Dr. Guilfoil, officers of the guild include:

Vice-President, Dr. Edmund J. Morrissey; secretary, Dr. Robertson Ward; treasurer, Dr. Wilber F. Swett; directors, Drs. Thomas E. Gibson, James J. McGinnis, Vance M. Strange and John Jay O'Connor.—San Francisco *Call-Bulletin*, August 1.

### Forty San Francisco Physicians With Southern Pacific Hospital Organize First Medical Guild

In what is believed to be the first union of its kind, approximately forty San Francisco physicians, surgeons and dentists have formed a group called the Railroad Physicians and Surgeons Guild here, it was disclosed yesterday.

All are members of the staff of Southern Pacific Hospital in San Francisco.

A spokesman denied reports that the prime purpose of the guild is to provide a collective bargaining agency under provisions of the Wagner Act, declaring:

"We sought to organize, so that we could cooperate with the Southern Pacific Company, the hospital, and its board of managers to give better service.

"In our purposes outlined for the guild, collective bargaining was not one of them. However, if the occasion arose, we presume collective bargaining would be entailed.

"There appears to be nothing different in this guild in comparison to the various medical societies and organizations now in existence except that this is called a guild," said Dr. G. Dan Delprat, president of the San Francisco County Medical Society.

"As for collective bargaining—if and when it became necessary—the San Francisco County Medical Society has done some collective bargaining. This was when we had objected to the way the health service operated and we advocated that the system be changed."

Officers of the guild include Dr. James Guilfoil, president; Dr. Edmund J. Morrissey, vice-president; Dr. Robertson Ward, secretary; Dr. Wilber F. Swett, treasurer, and as directors, Drs. Thomas E. Gibson, James J. McGinnis, Vance M. Strange and John Jay O'Connor.—San Francisco *Examiner*. (For editorial comment, see p. 57.)

### U. S. Traffic Death Toll Hits 11,160

Chicago, July 29.—(AP.)—The nation's traffic death toll of 1,920 for June raised to 11,160 the total for the first six months of this year, the National Safety Council reported today.

The six-month figure was 1 per cent below the same period last year but 10 per cent higher than in 1943.

The June deaths figured 11 per cent more than in the same month last year and 14 per cent greater than June, 1943. Mileage in May, the council said, was between 4 and 5 per cent over May, 1944.—Los Angeles *Times*, July 30.

### California Federation of Business and Professional Women Urges Study of State Health Plan

"The average woman does not know enough about the provisions of her insurance and social security," according to Mrs. Helen Matlock, who is spearheading the campaign of "Educate—Not Legislate" for California Federation of Business and Professional Women. Mrs. Matlock, president of the local B.P.W. Club and legislative and political chairman for the State group of 10,000 women, is largely responsible for the committee of five to be appointed within the next few days by the State president, Miss Ethel M. Johnstone of San Francisco.

The committee will study provisions of pending legislation affecting health and insurance in California and be



prepared to express an intelligent opinion on the measures when the special session of the legislative convenes next January.

"The intense feeling aroused by Governor Warren's proposed health bills in the recent sessions showed how deeply concerned the people are over anything that affects their health," Mrs. Matlock pointed out.

"Yet most of them know very little about the laws that govern our insurance and hospitalization. Our job as a federation should include a thorough study of the existing laws and proposed bills, followed by a poll of our members so that next year we can say to our representatives: 'Here is what 10,000 women want in the way of health legislation.'"

"Most of the federation members are employed women, and that means that the provisions of the social security laws are of vital importance to them," Mrs. Matlock stated.

She is asking for another committee of five women from all parts of the State to study the status of social security laws, especially as they affect women, and to report their findings to district and local clubs. . . .—*Sacramento Union*, July 22.

## MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.

*San Francisco*

### Evidence of Malpractice

The case of *Dixon v. Norberg* (157 Pac. 2d 131), decided March 12, 1945, by the Supreme Court of Colorado, illustrates the very slight evidence which will justify submission of a malpractice case to a jury for decision, and will support a verdict against a defendant physician and surgeon.

In the *Dixon* case the undisputed testimony disclosed that the plaintiff, while eating, swallowed a small pork bone, which became lodged in her throat, and caused such distress that she visited the defendant physician's office immediately, with her husband, for treatment.

There the defendant, after making two unsuccessful attempts to remove the bone by means of an instrument carrying a piece of surgical cotton on it, told plaintiff that he could do nothing more for her and that she should consult a specialist. He then called another physician, who instructed him to take x-rays, which he did, and then sent plaintiff to the specialist. This physician, by means of an esophagoscope, removed the bone. He first located some cotton on the left side of the esophageal wall. This cotton was on the pork bone, and when the cotton was removed the bone came with it. Subsequent examination disclosed a tear in the esophageal wall. No damage was occasioned by use of the esophagoscope itself.

As a result of the tear in the esophagus plaintiff became seriously ill and brought this action against the defendant for malpractice, alleging that he had treated her negligently in attempting to remove the bone, thus injuring the esophageal wall.

Defendant testified that when plaintiff consulted him he detected a foreign body in her throat, and, by means of a laryngeal forceps with a piece of surgical cotton on the end, he tried to wipe this foreign body from the throat with a sweeping motion from below upward. Being unsuccessful, he called the specialist, who was ultimately successful in removing the bone. The defendant stated positively that he did not insert the forceps down the esophagus of the plaintiff to the point where the specialist testified the pork bone was located, and that it would have been physically impossible to have done so.

Another physician, called by defendant as a witness, testified that the method used by defendant was approved in the general practice of medicine in the community.

Plaintiff testified that the defendant did put the forceps down her throat, and that she felt a sharp pain, and that immediately afterwards there was some hemorrhage.

There was medical testimony to the effect that the cotton might have been swallowed by plaintiff in the operations heretofore discussed, and in its journey down the esophagus, have come in contact with the bone and adhered thereto. It was also testified that the adherence of the cotton to the bone was so firm that the impact between the bone and the cotton must have been with more force than that involved in the act of swallowing. Although defendant testified that plaintiff complained of the foreign body being in the upper reaches of her throat, the specialist testified that when defendant telephoned him he had stated that the patient in the office had a bone in her esophagus.

Other medical specialists called by plaintiff, contrary to the testimony of defendant's witness, stated that the manner in which defendant probed for the bone in the esophagus was not good practice considering "the present standards in the profession for a general practitioner."

The jury rendered a verdict for the plaintiff in the sum of \$7000.00.

On appeal the principal question presented to the court was whether there was sufficient competent evidence in plaintiff's favor to warrant submission of the case to the jury. The court held that here there was a conflict in the testimony which warranted its submission to the jury, and the evidence in plaintiff's favor was sufficient to justify the verdict rendered.

The court approved the following instruction given to the jury by the trial court:

"You are instructed that in judging the proper degree of skill to be exercised by a physician or surgeon in any given case, regard is to be had to the advanced state of the profession at that time, and that a physician or surgeon by holding himself out to the world as such impliedly contracts that he possesses the reasonable degree of skill, learning and experience which good physicians and surgeons of ordinary ability and skill, practicing in similar localities, ordinarily possess, and that he will use his skill with ordinary care and diligence according to the circumstances of the case, and if you find that the defendant in this case did not use ordinary care and diligence then you will find for the plaintiff."

The Supreme Court, therefore, considered the testimony offered on behalf of plaintiff sufficient to establish a departure from the standard of care or degree of skill which justified a verdict against the defendant for malpractice.

## LETTERS†

Concerning C. and W. M. article on "Black Widow Spider":

(COPY)

SIMMONS-BOARDMAN PUBLISHING CORPORATION

Chicago, Ill., 14 July 1945.

*To the Editor:* I am writing to you at the suggestion of the American Medical Association to ask if I may quote two or three paragraphs from an article which appeared in the November, 1935, issue of *CALIFORNIA AND WESTERN MEDICINE*.

The article in question deals with the Black Widow spider (*Lactrodectus mactans*), and was written by Dr. Russell M. Gray of Indio, California.

† Editor's Note.—This department of *CALIFORNIA AND WESTERN MEDICINE*, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

† *CALIFORNIA AND WESTERN MEDICINE* does not hold itself responsible for views expressed in articles or letters when signed by the author.

If I am granted permission to use this material, I intend to incorporate it in an article I am writing on the Black Widow spider for one of the outdoor sports magazines. I should inform you that my article does not pretend to be the least bit technical, but instead attempts to acquaint outdoor men and women with the appearance of the spider and the location in which it is most likely to be found.

The section from which I would like to quote various paragraphs concerns Case No. 4, and also the "comment" which followed a report on that case.

Needless to say, full credit will be given in my article for any material I am permitted to use from your journal.

Yours very sincerely,

(Signed) H. E. MEASON,  
Associate Editor.

**Concerning Dr. L. J. Regan's article on "Malpractice Actions":**

(COPY)

THE CONNECTICUT STATE MEDICAL JOURNAL

New Haven, July 16, 1945.

*To the Editor:* We would like very much to reprint an article by Dr. L. J. Regan on Malpractice Actions, which appeared in the February, 1945, issue of your journal, and I am writing to ask permission to do this. We will, of course, give you full credit for the original publication. (Ed. Note.—Permission to reprint was given.)

Very truly yours,

(Signed) HERBERT THOMS, M.D.,  
Editor.

**Concerning Reaction of an Over-Seas C.M.A. Member to Proposed Compulsory Sickness Insurance Bills:**

25 June, 1945.

*To the Editor:* Please allow me to congratulate the California Medical Association for having waged such a successful fight against Compulsory Health Insurance. The Association has earned and won the undying gratitude of every physician in the Armed Service. To see such a united front presented by the Association in these days of great stress is indeed gratifying. . . .

It is indeed heartening to those of us so far from home to know that the California Medical Association has spoken as one voice and has proclaimed to the social planners and to the world that the enemies of scientific medicine who continue to dissipate their energies in the persistent espousal of lost causes, will not be able to use California as a proving ground for any crackpot schemes that have to do with the care of the sick.

It has long been a source of interest to me that the reformers who have invariably made failures of their own endeavors have always been the first to take up the cudgels in order to defend someone else to achieve the more abundant life.

I am at this very moment en route from a visit to a foreign country which has had Socialized Medicine for years—a country which by virtue of its compactness and homogeneous population should be ideal for this type of medical practice.

My one regret is that Governor Warren, whose sincerity I have never questioned, could not have accompanied me.

Here could be seen Socialized Medicine as it *really* is—not as the politicians and social planners who have come to know more about medical practice than the doctors themselves, would have you believe, but how it is actually looked upon by patients and physicians alike. First of all, the patients do not like it and the doctors

do not care, because they are all government employees and are not by any means a progressive type of medical man. If any specialized care were needed they availed themselves of the American doctors in the Army Hospital.

In the best civilian hospital the equipment was about what would be found in a small town American Hospital in the year 1910. An American Army doctor had come down several weeks previously and put a body cast on a patient and this procedure was of sufficient magnitude in the minds of the hospital personnel to still be the principal topic of conversation.

The better accommodations consisted of small rooms just large enough for two beds and room to walk between them. A large crust of bread thrown carelessly on a little stand at the head of each bed for the patients to gnaw on between meals bore mute evidence of the lack of finesse and adequate nursing facilities in this, their leading hospital.

What a garish contrast this picture presents between the best hospital available in a country with Socialized Medicine and our own magnificent American hospitals to which poor and rich alike may have access by paying a pittance in the form of Voluntary Hospital Insurance.

But this is not the real tragedy, because perhaps a crust of bread and a little less hospital luxury might have a salutary effect upon a great mass of pampered Americans. The real tragedy is the same tragedy that will befall America, not with the advent of Socialized Medicine, but will follow inevitably in its wake. I refer to the inferior caliber of medical men content to work under such a system. Here is a glaring example of a high grade American doctor, a product of free enterprise in a free America, whose ideals which we are supposed to be fighting to preserve, being called to a hospital to apply a body cast, simply because the political doctors had not had sufficient training to perform this elementary procedure.

So it is easy to see that what at first might be a pleasant rarity may soon become an opulent curse. Less than one generation under Socialized Medicine will lower the caliber of our medical men in these United States to the level just described, and let me say to the politicians and social planners who are attempting to foist this diabolical scheme on the American people that subsequent years will prove only too eloquently the justice of my belief. . . .

Of course the fight is far from won and there is no room for complacency. . . .

I cannot refrain from reminiscing for a moment and looking back up the avenues of time to the autumn of 1933 and the Annual Meeting of the American College of Surgeons in Chicago. The late Dr. J. Bentley Squier of New York who was president of the College presented a most eloquent and scholarly retiring address. He spoke of the unforeseen machinations that might endanger the high class system of medical practice as we know it today and sounded a warning note against Socialized Medicine when he said: "To be merely a cog in the wheel of a great machine can never be the ambition of those who have raised Medicine to its present high position or of those who have carried it onward."

He stated further that: "Any system which tends to lessen individual initiative cannot be the system which in the end will most stimulate scientific progress."

And in this connection with the stirring words of J. Bentley Squier still ringing in my ears an interesting thought comes into my mind. That thought is that the politicians, social planners and Doctors of Philosophy who have come to look upon themselves as better custodians of the people's health than the Doctors of Medicine who have performed this function so admirably for more than two thousand years, will not have to wait a



generation to put an inferior type of medical man into their socialistic scheme for political medicine. . . .

Of course the politicians, the Doctors of Philosophy and the social planners are fully conversant with all of this. It is up to Scientific Medicine to see that the victims of this diabolical scheme, namely the people of California and the nation are equally conversant. . . .

For the untiring efforts of the California Medical Association in behalf of Scientific Medicine the Medical men of the Armed Forces salute you.

I have every confidence that with your unfaltering assiduity for work the people of California will be duly informed as to the facts about Socialized Medicine in all of its pristine glory. . . .

With kindest personal regards, I am

Respectfully yours,

(NAME)

Fleet Post Office,

San Francisco, California.

### Alabama's Venereal Disease Program

An article by June Stafford in "Science Service" gives the following information:

For 45 days, Birmingham, Alabama, recently was the focal point for the first step in an unique mass attack on syphilis and gonorrhea launched by the State of Alabama.

The campaign, which started off with a survey in Birmingham and Jefferson counties May 15-June 30, was originated when the Alabama State Legislature, at the instigation of State Senator Bruce Henderson, Wilcox County plantation owner, passed a law requiring all persons in the State between the ages of 14 and 50 to have a blood examination, and those having syphilis to get treatment either from a physician or free through the State Health Department. Huge posters lined the streets of cities in the two counties:

"Penicillin Cures Gonorrhea (The Great Crippler and Sterilizer) in Four Hours."

"Syphilis Can Be Treated with Penicillin in Nine Days." Other messages point out that the penicillin is free.

The campaign was held with the aid of the U. S.

Public Health Service, which developed the techniques and supplied equipment adequate for such a large-scale task. . . .

To make the blood tests on every 14-to-50-year-old in Birmingham and Jefferson county (there are 300,000 of them), teams of skilled blood-testers were sent down from the U. S. Marine Hospital at Staten Island.

"Willow Run" was the name they gave to the blood-test laboratory set up here—the world's largest—because of the volume of work done and the assembly line procedure.

Physically, the laboratory was not so large. But it was equipped and staffed to make 20,000 blood tests a day. At the start of the campaign, when only 5,000 tests were being done daily, the staff had finished work by 2 p.m. Working at a snail's pace, the skilled blood-testing teams could each do 3,200 tests a day. By the end of the second week of the campaign, 95,600 blood samples had been tested for syphilis. . . .

*Honoré de Balzac (1799-1850).*—In his mode of living Balzac followed a strict but unwholesome régime during periods of literary production. He ate little, chiefly fruit; he drank strong coffee and Vouvray wine. Rest and relaxation were limited to five or six hours of sleep, and an hour's bath daily. Little wonder that such constant strain broke his physical endurance. Had he been as much devoted to Hygeia as to the literary Muse, his working life might have been lengthened—yet he produced ninety-seven volumes of imperishable prose in twenty years.—Warner's *Calendar of Medical History*.

*Ludwig van Beethoven (1770-1827).*—The tragic ear disease that affected Beethoven first appeared at 26 and became progressively worse, until at 44 he could no longer hear the orchestra he was conducting. Beethoven, desperate at first, railed against his fate and even contemplated suicide. But as the tumult within him died, his musical genius triumphed. Some of his finest symphonies were written while he was totally deaf. And though Beethoven suffered much pain and misery in his life, his noble music is for the most part serene and optimistic.—Warner's *Calendar of Medical History*.

(COPY)

### Communicable Diseases—Incubation Periods

*Morbidity and Mortality Report—From the Department of Health, City of Los Angeles*

NAME OF DISEASE	INCUBATION PERIOD FOR COMMUNICABLE DISEASE
Chancroid.....	1 to 10 days, usually 3 to 5 days.
Chickenpox.....	2 to 3 weeks.
Diarrhea of the Newborn, Epidemic.....	2 to 21 days, most frequently 6 to 7 days.
Diphtheria.....	Usually 2 to 5 days.
Dysentery, Bacillary.....	1 to 7 days, usually less than 4 days.
Food Infections (Salmonellosis).....	6 to 48 hours, usually about 24 hours.
Food Poisoning (Bacterial Intoxications).....	½ hour to 4 hours, usually 2 to 4 hours.
Botulism.....	18 to 36 hours.
German Measles.....	14 to 21 days, usually about 16 days.
Gonorrhea.....	1 to 8 days, rarely longer, usually 3 to 5 days.
Hemorrhagic Jaundice.....	4 to 19 days, average 9 to 10 days.
Influenza.....	Short, usually 24 to 72 hours.
Lymphogranuloma Venereum.....	1 to 4 weeks. Glandular enlargement appears in from 10 to 50 days.
Measles (Rubeola).....	About 10 days from date of exposure to onset of fever; 13 to 15 days until rash.
Meningococcus Meningitis.....	Generally considered to be 2 to 10 days, usually 7 days.
Mumps.....	From 12 to 26 days. 18 days accepted as usual.
Paratyphoid Fever.....	1 to 10 days; somewhat longer for paratyphoid A fever than B or C.
Pertussis (Whooping Cough).....	Commonly 7 days, almost uniformly within 10 days and not exceeding 21 days.
Pneumonia.....	Believed to be short, usually 1 to 3 days, not well determined.
Poliomyelitis.....	Considered to be 7 to 14 days.
Rabies.....	Usually 2 to 6 weeks. May be prolonged to 6 months or even longer.
Typhus.....	From 6 to 15 days, commonly 12 days.
Smallpox.....	7 to 16 days, commonly 12 days. May be 21 days.
Scarlet Fever.....	Short, usually 2 to 5 days.
Syphilis.....	About 3 weeks, minimum 10 days, occasionally 6 weeks or longer.
Tetanus.....	Commonly 4 days to 3 weeks, dependent somewhat upon the character, extent and location of the wound. Longer periods of incubation have been noted.
Trichinosis.....	Usually 6 to 7 days after ingestion of infective meat. G.I. symptoms may appear in 24 hours.
Typhoid Fever.....	From 3 to 38 days, usually 7 to 14 days.
Undulant Fever.....	6 to 30 days or more.

## TWENTY-FIVE YEARS AGO†

### EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 8, August, 1920

#### EXCERPTS FROM EDITORIAL NOTES

*Health Insurance and Physicians.*—Under the title above, there has been issued a pamphlet written by Dr. Frederick R. Green, secretary of the Council on Health and Public Instruction of the American Medical Association, which embodies the best formulation of principles on this topic which we have yet seen. . . .

We believe it self-evident that adequate medical service, in the sense which has many times been defined in these columns, is the right and due of every person in this country. We believe it is also self-evident that such service cannot be provided unless some one pays the bill. Good medical service costs money and must be paid for. One expedient suggested to make such service available for the large class of population which needs it most, is compulsory social insurance. It is a poor crutch and better are in sight, to be sure. But the purpose of social insurance is strictly and avowedly medical. . . .

Disagreement with the beginning argument of Dr. Green does not in any wise decrease our thorough accord with his conclusions nor does it lessen our hearty endorsement of his statement of the five alternatives besides compulsory health insurance, all better adapted to meet the problem that compulsory health insurance seeks imperfectly to meet. These alternatives are as follows:

1. Provision of a living and adequate wage.
2. Prevention of preventable disease by public health agencies, thus lightening the individual burden of sickness.
3. Development of individual thrift and savings to provide for a rainy day.
4. Development of voluntary industrial insurance in groups by employers and employees. This is a practical and efficient and coming method.
5. Development of voluntary benefit associations. . . .

*Politics and Health.*—It is unnecessary to state to those readers of the JOURNAL who are members of the State Medical Society that this JOURNAL is non-partisan and non-political and that it never appraises men or measures from the partisan standpoint but from the standpoint of public welfare.

An opportunity was given to the two great political parties, both of which claim to be devoted to the public welfare, to pronounce upon the subject of Public Health, which is the most vital question to the progress of the people individually and collectively.

The Republican party held its convention first this year and adopted a set of principles on which it seeks the endorsement of the voters. The platform of the Republican party on which it appeals to the people of the United States to entrust it with power at the coming November election contains the following health plank: . . .

We regret that the Democratic party at its National Convention in San Francisco failed to recognize the obligation of a great party to foster and further public health work. . . .

(Continued from Front Advertising Section, on Page 7)

† This column, compiled by the undersigned, strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

## BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M.D.

Secretary-Treasurer

### Board Proceedings

The Board of Medical Examiners at its regular meeting held in San Francisco July 9 to 12, 1945, took the following actions in regard to the status of licentiates:

The license of Dr. John J. L. Doyle was restored on July 9, 1945, and he was placed on probation for five years, without narcotic privileges, and with the proviso that he report to the Board once annually.

The certificate of Dr. Milton S. McMurtry was restored on July 9, 1945, and he was placed on five years' probation, to abide by all laws and report annually to the Board.

Dr. Samuel Joshua Apfel's California license was revoked under Section 2363 of the Business and Professions Code, because of revocation by another state. Said action was taken on July 10, 1945.

After a hearing on charges of violation of Section 2390 and 2391, Dr. James A. Hadley was placed on five years' probation without narcotic privileges and to report annually to the Board.

Dr. Benjamin F. Johnson's California license was revoked on July 10, 1945, under Section 2362 of the Business and Professions Code, revocation by another State Board.

Dr. Richard E. Orme was on July 10, 1945, placed on one year probation for alleged violation of Section 2392 of the Business and Professions Code, aiding an unlicensed practitioner.

### News

"Dr. Wesley L. Ricker, 43, of Fresno, was arrested at Weed, Thursday, and brought to the county jail here by Sheriff Ben Richardson on charges of practicing without a license. The defendant was out of jail Friday on \$1,000 bail." (*Yreka News*, May 11, 1945.)

"One of the nation's largest abortion mills was disclosed today by detectives with the arraignment of Hester Ann Hesketh, 50, on a charge of murder in connection with the death of a young navy wife. Chief of Detectives L. Q. Martin said Mrs. Hesketh admitted she performed 30 to 35 abortions a week for the past two years, or a total of more than 3,000 cases. . . . Mrs. Hesketh who talked freely to officers, was quoted as saying she had been performing abortions since coming to California 18 years ago. Her fees ranged from \$25 to \$75. She said she did not know her type of abortion could be fatal, and claimed Mrs. Reeves was the only patient to die. Most of her patients here, she said, were women with husbands in the armed services. She denied having any outside connections." (*Los Angeles Herald and Express*, June 12, 1945, from United Press dispatch, Long Beach, June 12.)

"Dr. Herman Benjamin Misch, whose license to practice was revoked last March on charges that he had performed an abortion, has demanded reinstatement by the State Board of Medical Examiners in a petition for a writ of mandate on file in Superior Court. Through

(Continued in Front Advertising Section, on Page 17)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the secretary of the board.



# REMOVE THE FOUR HYPOS



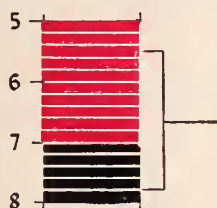
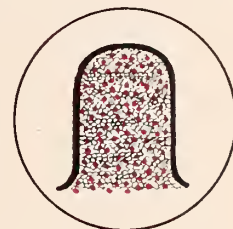
**1. HYPO-EPITHELIUM** (a decrease in the number of cell layers composing the vaginal mucous membrane, due to inflammatory hyper-desquamation).

**FLORAQUIN** by allaying the inflammatory reaction, destroying the pathogenic organisms and providing carbohydrates for mucosal glycogen, facilitates regeneration of the mucosa to normal.



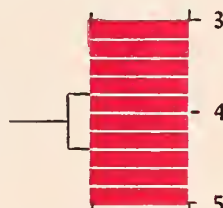
**2. HYPO-GLYCOGEN** (due to a marked decrease in the number of glycogen bearing cells of the vaginal mucous membrane).

**FLORAQUIN** makes available carbohydrates, lactose and dextrose, for absorption by the regenerating vaginal epithelium, and storage in the form of glycogen.



**3. HYPO-ACIDITY** (usually the vaginal pH is close to neutral, or even alkaline—pH 5.5 to 7.8).

**FLORAQUIN** provides a bacteriostatic acidity which, mixed with the vaginal secretion, re-establishes and maintains the normal pH of 3.8 to 4.4.



**4. HYPO-DÖDERLEIN** (a reduction or elimination of the Döderlein bacilli, the normal flora of the healthy vagina).

**FLORAQUIN** provides the ideal medium for the return and cultivation of the Döderlein bacillus which, by its action upon released glycogen, aids in maintaining normal acidity.



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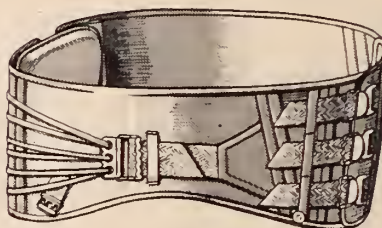
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## SURGEON GENERAL KIRK REPORTS ON HEALTH OF ARMY

(Continued from Page 26)

Malaria has been reduced from hundreds of cases per 1,000 men per year to less than 50. The dysenteries, which once put entire regiments and armies out of action, have occurred among less than 90 out of every 1,000 men per year and have been readily controlled. During World War I, 38 per cent of the men who contracted meningitis died, compared with 4 per cent in the present war, and 24 per cent of those who caught pneumonia died in 1918 compared with only seven-tenths of 1 per cent in this war.

No greater tribute can be paid to the Medical Department of our Army than the tribute paid by its record of saving lives in this war.

It is a record written by Medical Corpsmen following the troops into battle; by doctors performing their surgery amid the bursting of bombs; by the self-sacrifice of American women in the Nurse Corps, laboring long hours under the most difficult of conditions, by thousands of other Medical Department personnel, and by scientific research and development.

The Medical Department today is well prepared for the intensification of its work brought about by the cessation of hostilities in Europe. Thousands of wounded veterans in the European and Mediterranean theaters are being transported to the United States as fast as ships and planes are available. Physical examinations are being given to each of the 3,500,000 soldiers in those theaters before they are redeployed. And Medical Department personnel will be sent to the Pacific in ever-increasing

(Continued on Page 32)





Although successful treatment of food allergy may demand complete elimination of the offending food from the diet, the infant (or adult) for whom milk has become "forbidden food" need not be deprived of nutritional benefits of milk. • MULL-SOY, a *hypoallergenic* emulsified soy food, provides an ideal substitute for cow's milk. In standard dilution, it is equally rich in protein, fat, carbohydrate and minerals. MULL-SOY is palatable, well tolerated, and easy to digest. Of particular importance, younger patients *thrive* on Mull-Soy!

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## SURGEON GENERAL KIRK REPORTS ON HEALTH OF ARMY

(Continued from Page 30)

numbers as our forces are marshalled for the final blows against Japan.

The peak of the Medical Department's activities will not be reached until the fall of 1945. At present, wounded and sick are being returned to this country from all theaters at the rate of 44,000 a month. This evacuation will continue until all of the patients in the European and Mediterranean theaters are removed, which will require 90 days. . . .

In the Pacific areas our fighting men are exposed to many types of disease that are rare in the United States and Europe. However, this should not be considered cause for alarm. With proper preventive measures and medical service the disease rate in the Pacific will be kept to a minimum.

Every fighting unit in the Pacific area has had the same type of medical organization accompanying it as those in other theaters. The chain of evacuation of the wounded is well organized and is very effective. Because of geographical and climatic differences certain changes were desirable, but the same high type facilities are available.

The main diseases to be encountered in the Pacific are

malaria, the dysenteries, scrub typhus, skin infections, schistosomiasis, filariasis and dengue fever. Excellent progress has already been made in keeping the incidence of all of these diseases to a very low degree.

Malaria, for example, has been reduced to one-fourth its incidence in the early part of the war so that the overall death rate from malaria in the Army is .01 per cent.

The use of D.D.T. and atabrine is primarily responsible for lowering the incidence rate of the most disabling tropical diseases. The remarkable record in lowering the malaria rate is due also to strict discipline and control measures. Malaria is spread by the anopheles mosquito. D.D.T., a recently developed insecticide, is used to kill this mosquito and the larva. Areas are sprayed with D.D.T. by plane and a 5 per cent solution of D.D.T. sprayed on barracks walls in kitchens and huts kills all mosquitoes and flies alighting thereon for months after spraying.

The dysenteries, so common in the Pacific areas, which are spread by flies are also rendered less prevalent by the use of D.D.T.

Atabrine has been found more effective as a therapeutic agent in the control of malaria than quinine.

Filariasis, which is also spread by the mosquito, is reduced by the use of D.D.T. and mosquito control methods.

(Continued on Page 36)





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During the hay fever season—when the days of distress drag on and on—the consistent effectiveness of Neo-Synephrine assures prompt relief time after time. The last application before frost decongests as surely as the first.

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\*"Bactericidal Efficiency of Iodine Solutions and Organic Mercurial Antiseptics", Amer. Jour. Pharm., 117:5 (Jan.) 1945.

## IODINE

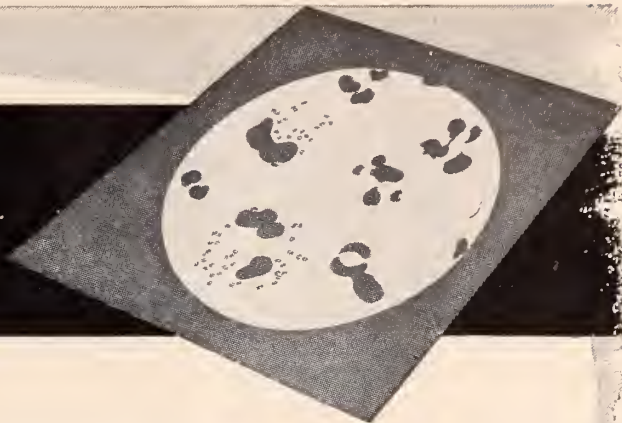
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**T**HOUGH the sulfonamides presented a signal advancement in the treatment of gonorrhea, many published reports indicate that penicillin is the therapeutic agent of choice for three potent reasons. First, *efficacy*: penicillin proves effective in virtually all instances. Second, *safety*: penicillin is practically nontoxic. Third, *brevity of treatment*: in the majority of cases, definite cure can be effected in 24 to 48 hours.

Studies at an Army Station Hospital showed that most sulfonamide-resistant gonococci are fully susceptible to penicillin; that penicillin resistance is difficult to establish.

*Frisch, A. W.; Behr, B.; Edwards, R. B., and Edwards, M. W., Am. J. Syph., Gonorr., & Ven. Dis. 28:527 (Sept.) 1944.*

From a study of 109 patients, the conclusion is drawn that penicillin effectively eradicates chemoresistant gonorrhea in the female.

*Greenblatt, R. B., and Street, A. R., J. A. M. A. 126:161 (Sept. 16) 1944.*

At a U. S. Naval Hospital, 200 cases of sulfonamide-resistant gonorrhea treated with penicillin, showed no toxic reactions; all returned to duty in one-third of the time previously required.

*Scarcello, N. S., New England J. Med. 231:609 (Nov. 2) 1944.*

"In the Technical Bulletin of Medicine, No. 26, recently issued by the War Department, penicillin is stated to be the drug choice in the treatment of gonorrhea."

*J. A. M. A. 126:575 (Oct. 28) 1944.*

191 consecutive cases of sulfonamide-resistant gonorrhea responded dramatically to penicillin.

*Wigh, R., and Geer, G. I. Jr., J. Maine M. A. 35:207 (Nov.) 1944.*

No toxic effects were observed in a series of sulfonamide-resistant gonorrhea of the female treated with penicillin. As compared to hyperpyrexia, penicillin treatment "is incomparably easier, simpler, safer, cheaper, and just as effective."

*Barringer, E. D.; Strauss, H., and Horowitz, E. A., N. Y. State J. Med. 45:52 (Jan. 1) 1944.*

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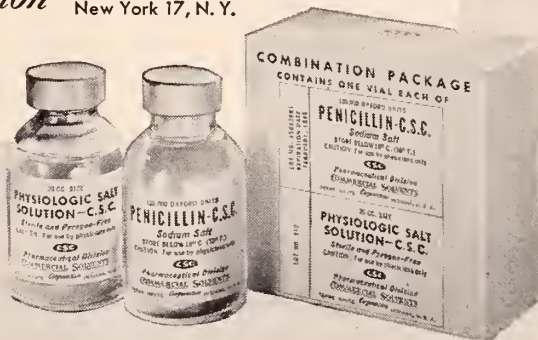
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### SURGEON GENERAL KIRK REPORTS ON HEALTH OF ARMY

(Continued from Page 32)

Schistosomiasis is caused by a small fluke found in pools and running streams which in a matter of seconds burrows through the skin and infects the individual. All water found to contain these flukes is posted and personnel is warned not to bathe, wade or wash in it.

Areas found to contain scrub typhus are immediately burned over, clothing is impregnated, and efforts are being made to develop a vaccine to counteract it.

Dengue fever, also spread by the mosquito, is controlled by the use of D.D.T. and mosquito abatement.

It can readily be noted that D.D.T. is one of the miracle developments of this war.

While all of this work and planning was going on for the increased activity in the Pacific the Army Medical Department during 1944 took care of 4,435,000 patients in hospitals—2,315,000 in the United States and 2,120,000 in hospitals overseas. In addition it provided care for an additional 43,210,000 nonhospitalized patients—those with minor infections and injuries who were only temporarily incapacitated.

It performed the essential functions of caring for men wounded in battle, the injured and the sick to maintain fighting strength with 45,000 medical corps, 15,000 dentists, 52,000 nurses, 2,000 veterinarians, 18,700 medical administrative corps men, 2,500 sanitary corps specialists, 1,000 physical therapists, 1,500 dietitians, 61 pharmacy corps officers, 535,000 enlisted medical aid men and approximately 80,000 civilian employees.

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### President Truman May Ask More Security

Washington (I.N.S.)—President Truman was reported today to be planning an early message to Congress seeking expansion of the Social Security Law.

The message, which would be the first major legislative recommendation of the new President, was said in congressional circles to be scheduled for next week.

"The President is very much interested in the subject," said Senator Wagner (D., N. Y.), co-author of the security law. "I think Congress will get a message on it."

Mr. Truman, it was reported, also will ask an emergency \$25 a week unemployment compensation for displaced war workers. This was a recommendation of former War Mobilizer James F. Byrnes, but was rejected by Congress.

Plans for a new far-reaching Social Security bill were discussed with the President by Wagner, Senator Murray (D., Mont.) and Representative Dingell (D., Mich.)

The new measure under present plans, will call for

an 8 per cent payroll tax—4 per cent on the employer and 4 per cent on workers—which is estimated to yield in peace time from five to eight billion dollars a year, depending on the number employed.—San Francisco *Call-Bulletin*.

### U.S.P.H.S. Chief Urges More Blood Tests

Washington, (Assoc. Press)—Blood tests should be made a part of all medical examinations, Dr. Thomas Parran, surgeon general of the United States Public Health Service, said on November 12.

Reporting to the Nation on the work done at the St. Louis conference of doctors and medical experts toward combating venereal diseases, Dr. Parran said in a talk prepared for broadcast (Blue Network-WMAL).

"More than 25 million Americans will receive blood tests this year but these must be done even more widely. Such tests should be a part of all medical examinations, as a routine test before marriage and during each pregnancy. These latter examinations are now compulsory in

(Continued on Page 40)

## In Allergic Rhinitis—

☞The inhalation from tubes of volatilizable vasoconstricting drugs is often very effective. The most popular and best known of this sort is the benzedrine (amphetamine) inhaler.☞

Feinberg, S.M.: Allergy in Practice, The Year Book Publishers, Inc., Chicago, 1944, "Hay Fever Treatment."

## A BETTER MEANS OF NASAL MEDICATION

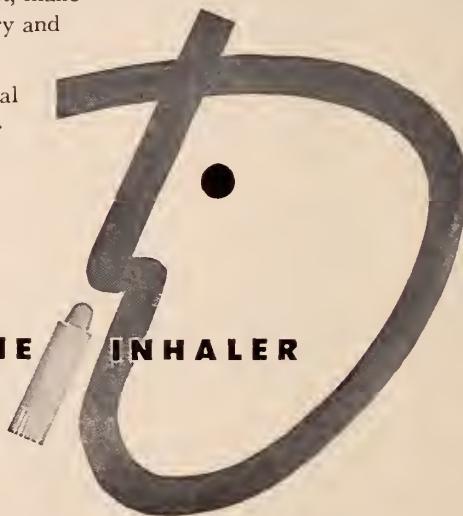
Between office treatments, the use of BENZEDRINE INHALER, N.N.R., will afford the allergic rhinitis patient marked symptomatic relief. It may, in fact, make all the difference between weeks of acute misery and weeks of comparative comfort.

The Inhaler produces a shrinkage of the nasal mucosa equal to, or greater than, that produced by ephedrine—and approximately 17% more lasting. It is, consequently, strikingly effective in reducing the congestion of hay fever, head colds, and sinusitis. Smith, Kline & French Laboratories, Philadelphia, Pa.




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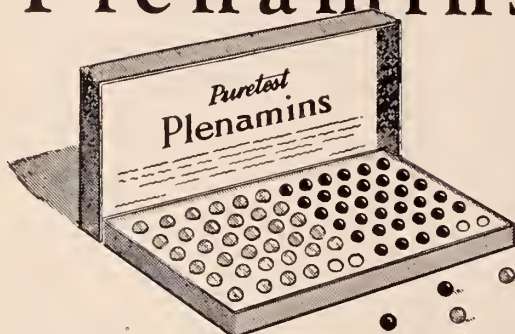
It seems obvious to us that the doctor, the patient and the manufacturer are all best served when these beneficent new therapeutic agents, the vitamins, are used with the physician's scien-

tific knowledge. Our vitamin products have been expressly formulated to this end—and to this same end are promoted with complete and *undeviating* regard for professional ethics.

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### U.S.P.H.S. CHIEF URGES MORE BLOOD TESTS

*(Continued from Page 37)*

many States and should be extended across the Nation."

Dr. Parran said it was the conviction of the more than 800 doctors, public health authorities, and educators who attended the St. Louis meeting that "syphilis and gonorrhea can be banished from this Nation."

As a result of the national campaign to control venereal disease begun in 1938, and intensified during the war, the American people are "getting dividends in terms of less illness and less disability," Dr. Parran declared.—*San Francisco Chronicle*.

### E.M.I.C.—Three-Quarters of a Million Servicemen's Wives and Babies Cared for Under Emergency Maternity and Infant Care Program

The count of servicemen's wives and babies authorized for care under the emergency maternity and infant care

program is now more than 750,000, says Katharine F. Lenroot, Chief of the Children's Bureau.

The Bureau, with State public-health departments, is responsible for administration of this program, by which medical, nursing, and hospital care are provided for the wife throughout pregnancy, childbirth, and for six weeks after childbirth and to the infant through its first year. Wives and infants of men in the four lowest pay grades of the Army, Navy, Marine Corps, and Coast Guard are eligible and also the wives and infants of Army and Navy aviation cadets. The care is provided for all, regardless of family income, race, or place of residence. There is no cost to the serviceman or his wife for her care or the care of her baby.

"With the return of servicemen to civilian life, one question regarding the program comes up with increasing frequency," Miss Lenroot said. "It has to do with

*(Continued on Page 42)*

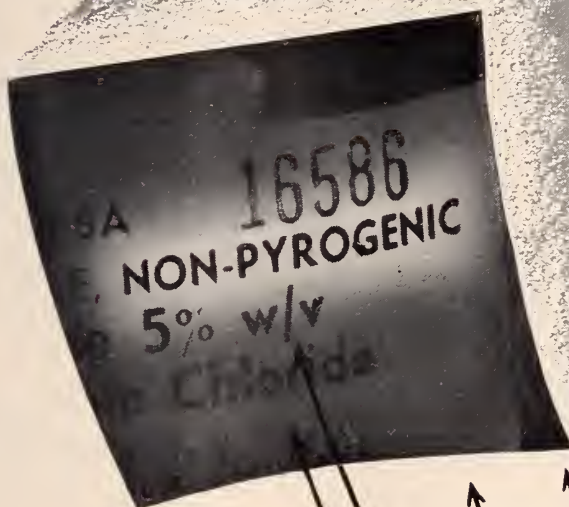
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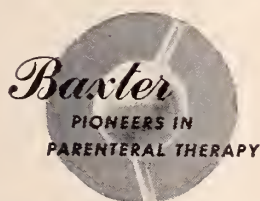
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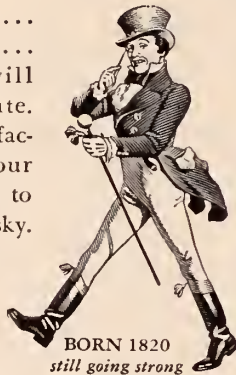
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### E.M.I.C. PROGRAM

(Continued from Page 40)

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A significant factor in our successful prosecution of the war has been the comparatively high level of education of our fighting men. In mechanized modern warfare a decisive advantage accrues to a nation in which high standards of education and technical training prevail. It is, therefore, indeed fortunate that extraordinary gains had been made in the spread of secondary and higher education among the American people in the period between the two World Wars.

The evidence is clear and convincing. Among white men in the age group 25 to 29 in 1940, nearly 40 per cent were high school graduates, about twice the proportion of two decades earlier.

Among young white women in the 20-year period under review, the proportion of high school graduates showed a very substantial increase, although not quite as marked as that for the men. Nevertheless, in 1940 as in 1920, a somewhat larger proportion of young women than men had completed high school.

A greater percentage of men than women, however, go on to college. Among white men 25 to 29 in 1940, 14.8 per cent had completed one or more years of college as compared with 13.6 per cent for young white women.

(Continued on Page 46)





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### MARKED RISE IN EDUCATIONAL LEVEL OF THE AMERICAN PEOPLE

(Continued from Page 42)

Moreover, of those who enter college, a considerably larger proportion of men than women complete the course. The per cent of college graduates among white men and women at ages 25 to 29 in 1940 was, respectively, 7.5 and 5.3. The difference, however, is somewhat smaller than it was 20 years ago, because the proportion of college graduates among young men had increased in the two decades about 42 per cent, as against nearly 47 per cent for young women.

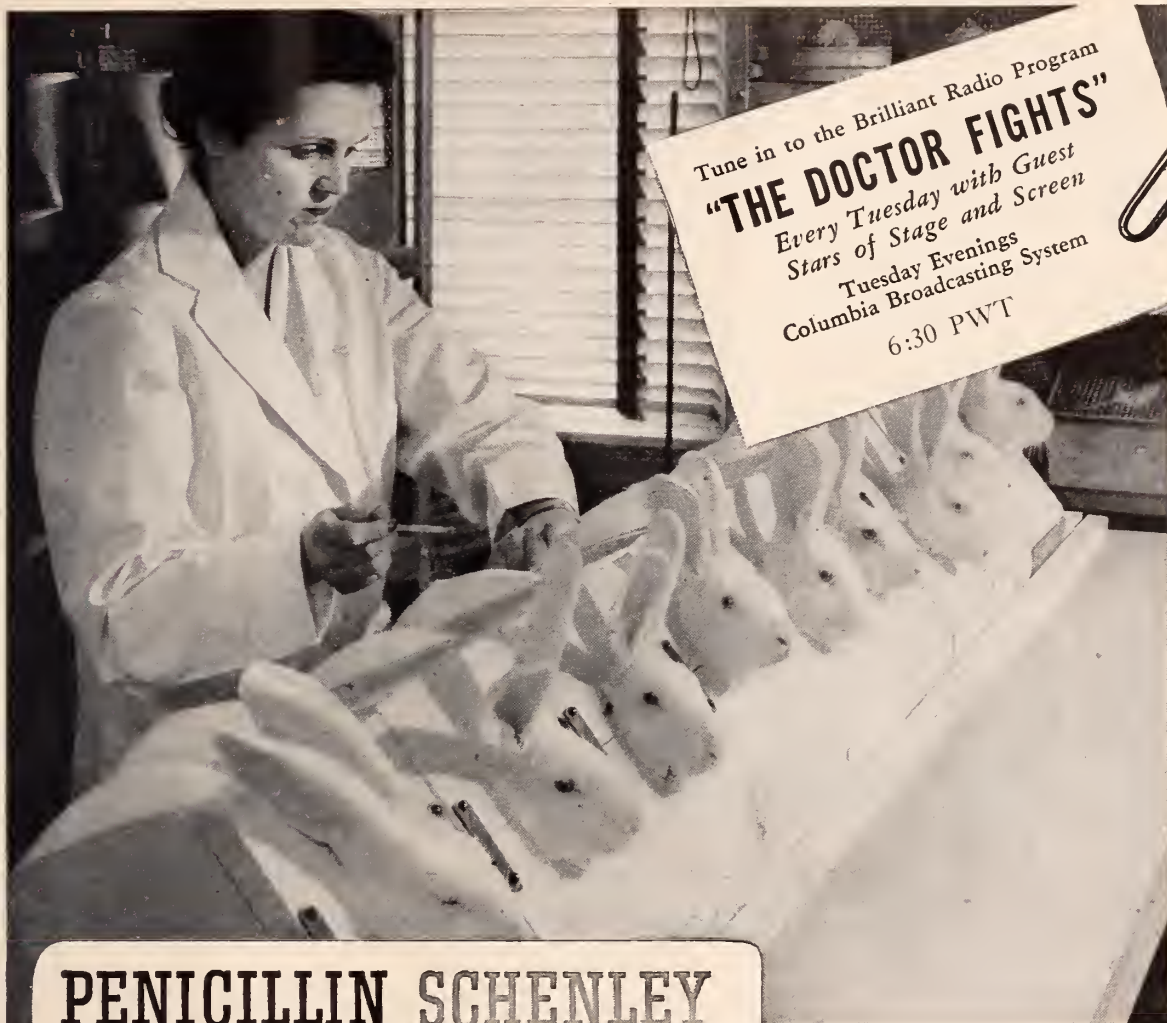
The proportion of young men with secondary or higher education is much larger in urban than in rural areas. According to the 1940 census, 46 per cent of young white men in urban areas were high school graduates, as against 35 per cent among those in the rural nonfarm population, and only 22 per cent in the rural farm areas. Even greater are the differences with respect to college graduates, the figures for the three areas being, respectively, 10 per cent, 6 per cent, and 1.5 per cent. These differences are not surprising, inasmuch as these institutions are located, for the most part, in or near cities

and towns. Also the urban population is better able to pay the costs of a college education and has more opportunity to utilize it.

In the period under discussion, the gains in secondary school education have been comparatively even greater for the colored than for the white population. The proportion of young colored men and women in 1940 who had completed at least one year of high school was more than double that two decades earlier, and except in the South, the ratios for the young colored population in 1940 was equal to or better than that of the white population 20 years earlier. The figures for college graduates among colored males, however, have shown only slight improvement. On the other hand, the educational level of Negro college graduates in recent years is probably much higher than it was 20 years ago. The proportion of young colored women who have received college degrees has increased more than 50 per cent.

The outlook is particularly good for the resumption of educational gains after the war. The colleges have played an important rôle in the training of hundreds of thousands of young men for the numerous technical jobs in the armed forces. This brought many young men into direct contact with colleges who otherwise would not have had this experience.





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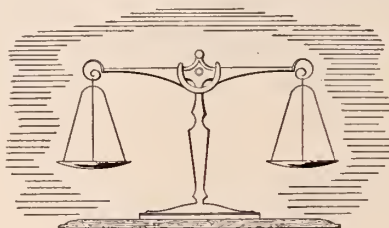
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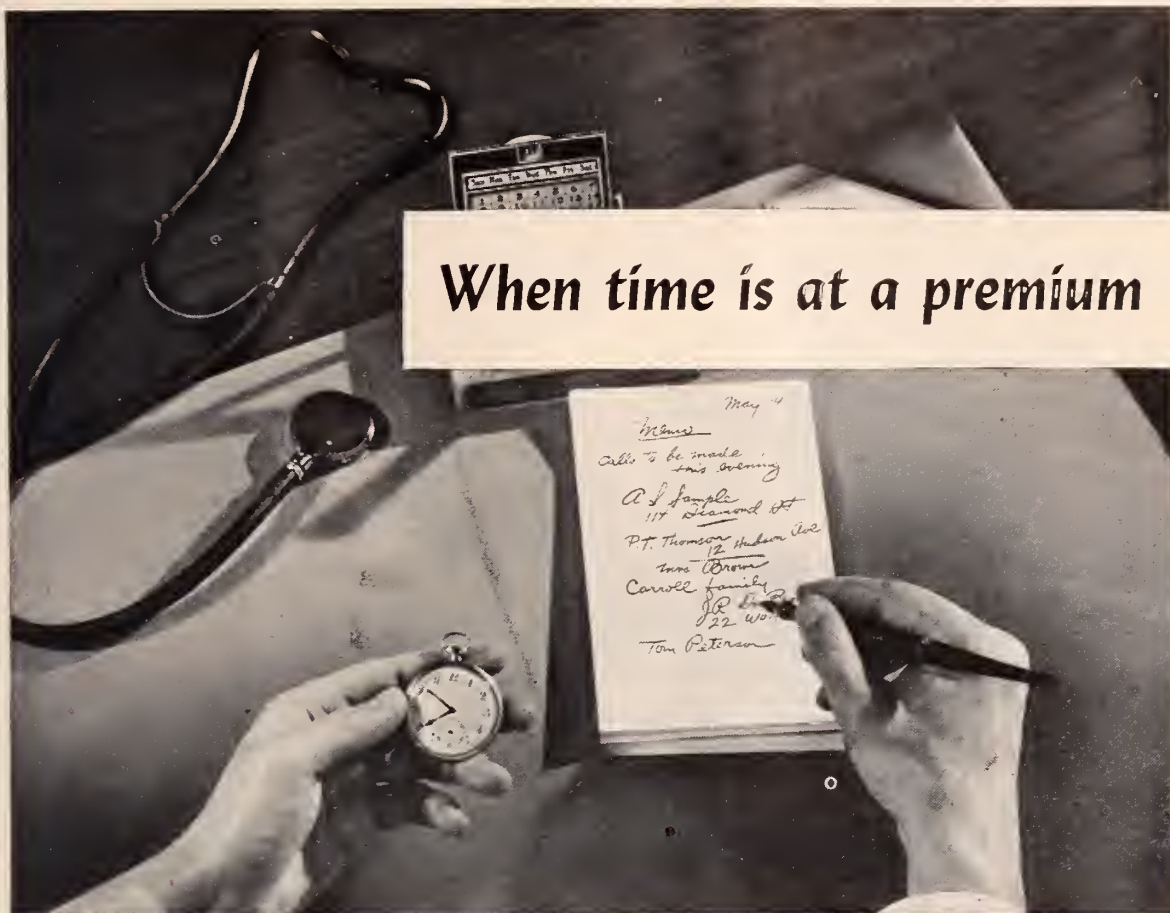
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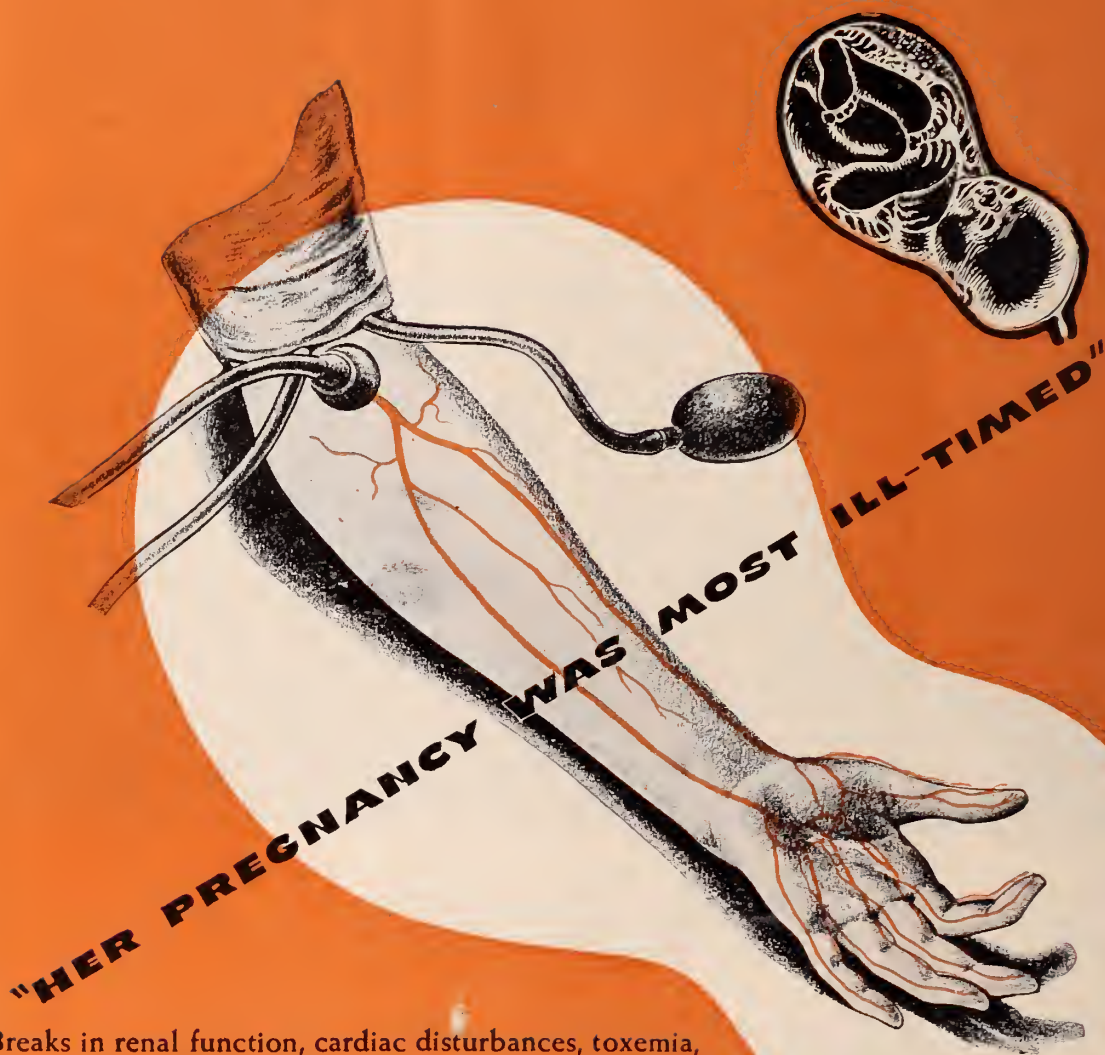
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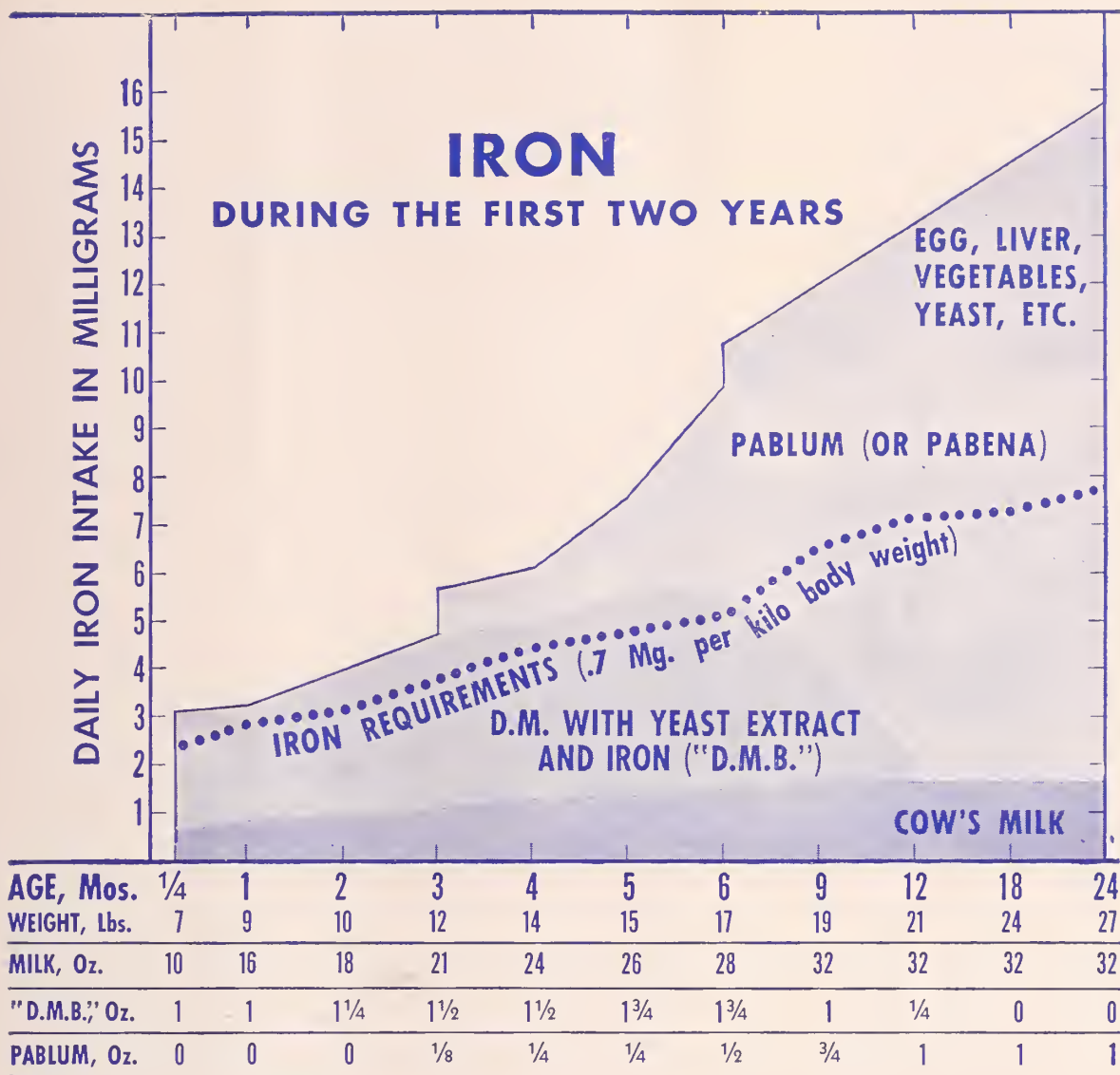


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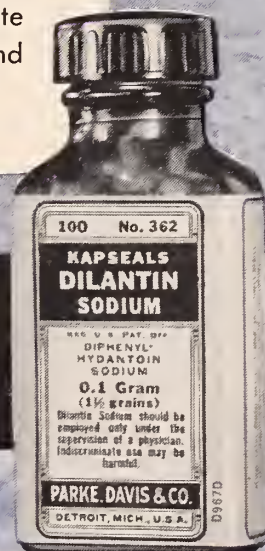


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Robert A. Peers.....	Colfax	1948	Francis L. Chamberlain. (ex officio, Secretary, Section on Medicine)		
George H. Kress.....	ex officio		Eugene J. Joergenson.. (ex officio, Secretary, Section on Surgery)		
Committee on Hospitals, Dispensaries and Clinics			Committee on Public Relations		
Benjamin W. Black.....	Oakland	1946	The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio.		
Roy E. Thomas .....	Los Angeles	1947	J. C. Geiger.....Chair, Com. on Health and Public Instruction		
Clarence E. Rees (Chairman).....	San Diego	1948	Clarence E. Rees...Chair, Com. on Hospitals, Dispensaries, Clinics		
Committee on Industrial Practice			Donald Cass.....Chair, Com. on Industrial Practice		
Carl L. Hoag.....	San Francisco	1946	Nelson J. Howard.....Chair, Com. on Medical Defense		
N. P. Dunne .....	Oakland	1947	Carl L. Mulfinger..Chair, Com. on Membership and Organization		
Donald Cass (Chairman).....	Los Angeles	1948	H. Gordon MacLean.....Chair, Com. on Medical Economics		
Committee on Medical Defense			Dwight H. Murray, Chair, Com. on Public Policy and Legislation		
Louis J. Regan.....	Los Angeles	1946	F. E. Clough.....Chair, Com. on Postgraduate Activities		
Nelson J. Howard (Chairman) .....	San Francisco	1947	Philip K. Gilman...President of California Medical Association		
William A. Key.....	San Mateo	1948	Sam J. McClendon.....President-Elect		
Committee on Medical Economics			George H. Kress.....Secretary-Treasurer		
Howard W. Bosworth.....	Los Angeles	1946	Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2004, 450 Sutter Street, San Francisco.		
Wayne J. Pollock.....	Sacramento	1947	Cancer Commission		
H. Gordon MacLean (Chairman).....	Oakland	1948	Lyell C. Kinney (Chairman).....	San Diego	1946
Committee on Medical Education and Medical Institutions			Harold Brunn .....	San Francisco	1946
William J. Kerr.....	San Francisco	1946	Orville N. Meland (Sec'y, Southern Calif.).....	Los Angeles	1946
B. O. Raulston (Chairman).....	Los Angeles	1947	George Sharp .....	Pasadena	1946
L. R. Chandler.....	San Francisco	1948	Whitfield Crane (Vice-Chairman).....	Oakland	1947
Committee on Organization and Membership			Gertrude Moore .....	Oakland	1947
L. H. Redelings.....	San Diego	1946	Henry J. Ullmann.....	Santa Barbara	1948
Carl L. Mulfinger (Chairman) .....	Los Angeles	1947	David A. Wood (Sec'y, No. California).....	San Francisco	1948
Harold G. Trimble .....	Oakland	1948	James F. Rinehart.....	San Francisco	1948
Committee on Postgraduate Activities			Physicians' Benevolence Committee		
F. E. Clough (Chairman).....	San Bernardino	1946	Axel E. Anderson, Chairman.....	Fresno	
H. F. Freidell.....	Santa Barbara	1947	Elizabeth M. Hohl.....	Los Angeles	
John C. Ruddock .....	San Diego	1948	Robert A. Peers.....	Colfax	
George H. Kress.....	ex officio				

\* Members appointed each year by the Chairman of the Council.



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Members who contemplate presentation of scientific papers should promptly address the secretary of the proper section, as per addresses which follow. Correspondence concerning scientific exhibits, and medical and surgical films, should be addressed to the Chairman of the Committee on Scientific Work: George H. Kress, M. D., 450 Sutter, San Francisco.

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# ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

**Alameda County Medical Association**  
364 14th St., Oakland 12  
President, Harry J. Templeton, 3115 Webster Street, Oakland.  
Secretary, Gertrude Moore, 353 30th Street, Oakland, 9.  
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

**Butte-Glenn County Medical Society**  
President, John H. Alexander, 2nd at Main Street, Chico.  
Secretary, J. O. Chiappella, 131 Broadway, Chico.  
Meeting, *Second Thursday.*

**Contra Costa County Medical Society**  
President, Joseph W. Boomer, American Trust Building, Richmond.  
Secretary, Henry W. McNeerney, 2600 McDonald Avenue, Richmond.  
Meeting, *Second Tuesday, 8:00 p. m.*

**Fresno County Medical Society**  
President, John E. Young, Rowell Building, Fresno.  
Secretary, K. D. Luechauer, 1759 Fulton Street, Fresno.  
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

**Humboldt County Medical Society**  
President, Nathan G. Wasserman, 539 G Street, Eureka.  
Secretary, Joseph S. Woolford, 539 G Street, Eureka.  
Meeting, *First Thursday.*

**Imperial County Medical Society**  
President, T. E. Bartholomew, 319 Third Street, Calexico.  
Secretary, Marian Hubbell, El Centro.  
Meeting, *Third Tuesday, 7:00 p. m., Barbara Warth Hotel, El Centro.*

**Inyo-Mono County Medical Society**  
President, James Lloyd Mason, Bishop.  
Secretary, Walter L. Wilson, 108 N. Main, Bishop.  
Meeting, *Fourth Wednesday, except December, January, February.*

**Kern County Medical Society**  
President, Sophie L. Goldman, 458 Habersfelde Building, Bakersfield.  
Secretary, Julie Thorner, 109 Eighteenth Street, Bakersfield.  
Meeting, *Third Thursday, 7:30 p.m., Bakersfield Inn, except June, July, August.*

**Kings County Medical Society**  
President, Lionel W. Sorenson, 1118 Whiteley Avenue, Corcoran.  
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.  
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

**Lassen-Plumas-Modoc County Medical Society**  
President, Fred J. Davis, Jr., 920 Pine Street, Susanville.  
Secretary, J. W. Crever, Susanville.  
Meeting, *On Call.*

**Los Angeles County Medical Association**  
1925 Wilshire Boulevard, Los Angeles 5  
President, J. Jay Crane, 418 South Arden Street, Los Angeles 5.  
Secretary, E. T. Remmen, 429 North Orange, Glendale 3.  
Meeting, *First and Third Thursday, 1925 Wilshire Boulevard, Los Angeles.*

**Marin County Medical Society**  
President, Alex Miller, 1010 B Street, San Rafael.  
Secretary, Carl W. Clark, 1010 B Street, San Rafael.  
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rack Hotel, Larkspur.*

**Mendocino-Lake County Medical Society**  
President, J. E. Gardner, 215 W. Standley Street, Ukiah.  
Secretary, Dale E. Barber, Fort Bragg.

**Merced County Medical Society**  
President, E. R. Fountain, Merced.  
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.  
Meeting, *Third Thursday, Hotel Tioga, Merced.*

**Monterey County Medical Society**  
President, Edwin Wiley Reeves, 605 Salinas National Bank Building, Salinas.  
Secretary, Dixi M. Bingaman, Bank of America Building, Salinas.  
Meeting, *First Thursday.*

**Napa County Medical Society**  
President, Charles H. Bulson, 1203 Seminary Street, Napa.  
Secretary, M. M. Booth, Bruck Building, St. Helena.  
Meeting, *First Wednesday.*

**Orange County Medical Association**  
President, L. F. Whittaker, 302 Third Street, Huntington Beach.  
Secretary, Russell I. Johnson, 181 Seventeenth Street, Westminster.  
Meeting, *First Tuesday, 7:00 p.m., Windsor Cafe, Santa Ana*

**Placer-Nevada-Sierra County Medical Society**  
President, George A. Foster, Grass Valley.  
Secretary, Vernon W. Padgett, Grass Valley.  
Meeting, *At Call of President.*

**Riverside County Medical Society**  
President, Omer W. Wheeler, 1939 La Cadena, Riverside.  
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.  
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

**Sacramento Society for Medical Improvement**  
President, Maurice A. Hopkins, Route 7, Box 1246A, Sacramento.  
Secretary, Edmund E. Simpson, 1127 Eleventh Street, Sacramento 14.  
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

**San Benito County Medical Society**  
President, J. M. O'Donnell, Hollister.  
Secretary, J. J. Haruff, Hollister.  
Meeting, *At Call of President.*

**San Bernardino County Medical Society**  
President, J. J. H. Smith, 137 East H Street, Colton.  
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.  
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

**San Diego County Medical Society**  
President, George D. Huff, 806 Medical Building, San Diego 1.  
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego, 1.  
Meeting, *Second Tuesday, University Club.*

**San Francisco County Medical Society**  
2180 Washington Street 9  
President, G. Dan Delprat, 384 Post Street, San Francisco 8.  
Secretary, Chester L. Cooley, 490 Post Street, San Francisco, 2.  
Meeting, *Second Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco, 9.*

**San Joaquin County Medical Society**  
President, Yale Brody, Bank of America Building, Stockton 5.  
Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton 2.  
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

**San Luis Obispo County Medical Society**  
President, Edward C. Sherman, 784 Marsh Street, San Luis Obispo.  
Secretary, G. D. Kelker, 1114 Marsh Street, San Luis Obispo.  
Meeting, *Fourth Wednesday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

**San Mateo County Medical Society**  
President, Logan Gray, 57 Fourth Avenue, San Mateo.  
Secretary, J. Paul Sweeney, P. O. Box 1004, Millbrae.  
Meeting, *At call of President.*

**Santa Barbara County Medical Society**  
President, George R. Lutton, 103 E. Micheltorena Street, Santa Barbara.  
Secretary, Charles A. Preuss, 1317 Santa Barbara Street, Santa Barbara.  
Meeting, *Second Monday, Cottage Hospital.*

**Santa Clara County Medical Association**  
President, Karl F. Pelkan, 903 Medico Building, San Jose.  
Secretary, Fred W. Borden, Sainte Claire Building, San Jose, 23.

**Santa Cruz County Medical Society**  
President, Anton J. Sambuck, Union Street and Maple Avenue, Watsonville.  
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.  
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

**Shasta-Trinity County Medical Society**  
President, L. C. Mosher, Bieher.  
Secretary, Julius M. Kehoe, Redding.  
Meeting, *Second Monday.*

**Siskiyou County Medical Society**  
President, H. L. Vidricksen, Weed Hospital, Weed.  
Secretary, F. W. Martin, Mt. Shasta.  
Meeting, *Sunday on Call.*

**Solano County Medical Society**  
President, H. Randall Madeley, P. O. Box 539, Vallejo.  
Secretary, John W. Green, Box 539, Vallejo, California.  
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.*

**Sonoma County Medical Society**  
President, William N. Makaroff, Guerneville.  
Secretary, Robert S. Quinn, 3325 Chanate Road, Santa Rosa.  
Meeting, *Second Thursday.*

**Stanislaus County Medical Society**  
President, J. H. Czatt, 810 Fourteenth Street, Modesto.  
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.  
Meeting, *Second Friday, 7:30 p.m., Hotel Huglson.*

**Tehama County Medical Society**  
President, James L. Faulkner, Red Bluff.  
Secretary, R. G. Frey, Red Bluff.  
Meeting, *At Call of President.*

**Tulare County Medical Society**  
President, Charles M. Mathias, 515 Kern Street, Tulare.  
Secretary, James C. Malcolm, 1501 West Main, Visalia.

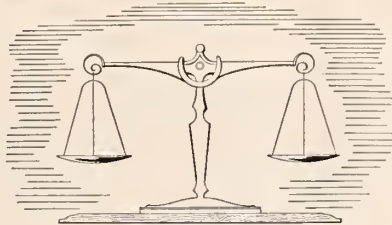
**Ventura County Medical Society**  
President, Gerald K. Ridge, 704 East Santa Clara Street, Ventura.  
Secretary, George H. Arnold, Route 2, Box 12, Ventura.  
Meeting, *Second Tuesday, Ventura County Country Club.*

**Yolo County Medical Society**  
President, William J. Blevins, Sr., 212 Porter Building, Woodland.  
Secretary, Emery Leivers, Woodland Clinic, Woodland.  
Meeting, *First Wednesday.*

**Yuba-Sutter-Colusa County Medical Society**  
President, Joseph D. Lewis, 725 Fourth Street, Marysville.  
Secretary, Thomas F. Keyes, 725 Fourth Street, Marysville.  
Meeting, *Second Wednesday.*

(For roster of C.M.A. committees and other organization, see last month's issue.)





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Hospital Service of California, 364 Fourteenth Street, Oakland, 12. (Phone Hlgate 7600.) 153 Kearny Street, San Francisco, 8. (Phone GARfield 0813.) 67 East Santa Clara, San Jose.

Hospital Service of Southern California, 743 South Grand View Street, Los Angeles. (Phone DRexel 5261.)

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento. (Main 2548.)

### California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MONTrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WEst 8000, Extension 75.

Barlow Medical Library (Los Angeles County Medical Association), 634 So. Westlake, Los Angeles 5. Phone FITzroy 7694.

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## BOOK REVIEWS

### BOOKS RECEIVED

**Virus As Organism.** Evolutionary and Ecological Aspects of Some Human Virus Diseases. By Frank MacFarlane Burnet, M.D., F.R.S., Director, Walter and Eliza Hall Institute of Research in Pathology and Medicine, Melbourne, Australia. Cloth. Price, \$2.00. Pp. 134. Cambridge, Massachusetts: Harvard University Press, 1945.

Dr. Burnet's book discusses the more important virus diseases of man from a biological point of view, the central theme being that viruses are microorganisms which have evolved by parasitic degeneration from larger microorganisms, many of them in all probability from bacteria.

**Pulmonary Edema and Inflammation.** An Analysis of Processes Involved in the Formation and Removal of Pulmonary Transudates and Exudates. By Cecil K. Drinker, M.D., D.Sc., Professor of Physiology, School of Public Health, Harvard University, Boston, Mass. The Nathalie Gray Bernard Lectures Delivered at The Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, North Carolina, in December, 1944, Together with a Fifth Chapter on Artificial Respiration. Cloth. Price, \$2.50. Pp. 106, illustrated. Cambridge, Massachusetts: Harvard University Press, 1945.

This volume by Dr. Cecil K. Drinker of Harvard explains the genesis and spread of pulmonary edema, and discusses the principles involved in its prevention and treatment. The monograph concludes with a review of the problems and techniques of artificial respiration.

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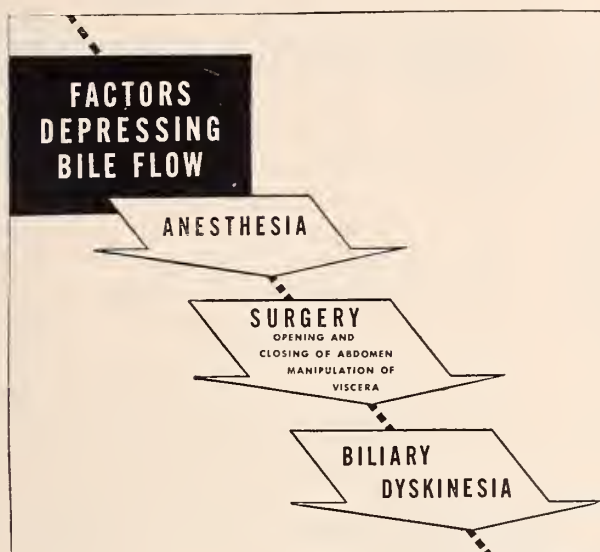


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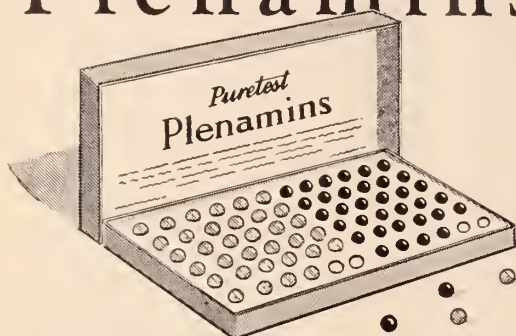
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**San Francisco**

### BOOK REVIEWS

(Continued from Page 7)

**Control of Pain in Childbirth—Anesthesia, Analgesia, Amnesia.** By Clifford B. Lull, M.D., F.A.C.S., Clinical Professor of Obstetrics, Jefferson Medical College; Assistant Director, Philadelphia Lying-In Unit, Pennsylvania Hospital; and Robert A. Hingson, M.D., Surgeon, U. S. Public Health Service; Director, Post-graduate Medical Course, Philadelphia Lying-In Unit, Pennsylvania Hospital. With an introduction by Norris W. Vaux, M.D., Obstetrician-in-Chief, Philadelphia Lying-In Unit, Pennsylvania Hospital. Cloth. Price, \$7.50. Pp. 356, with 100 illustrations in black and white and 32 subjects in color. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944.

Throughout the ages men have sought diligently for methods of alleviating pain, particularly that pain which is associated with parturition. The discovery of anesthesia removed the barrier to progress in surgery and the employment of general anesthesia, because of its

incalculable aid in allaying the sufferings of humanity, greatly increased the scope of the surgeon's usefulness. Shortly after the finding of ether, the anesthetic powers of chloroform were discovered first by Sir James Simpson of Edinburgh and this agent was introduced into his special department, midwifery.

Since the advent of anesthesia there have been employed many agents for the relief of suffering during childbirth and each advance has been a step along the way of total conquest of pain. Chief among these are ether, ethylene, nitrous oxide and oxygen, morphine and scopolamine, and "twilight sleep." The latter was very popular for a time, as were the others in their turn, but within the last few years this has been rapidly lapsing into obscurity. Today we have in the form of caudal analgesia the greatest achievement thus far advanced.

In the writing of this book the authors have been motivated by four dominant purposes: (1) The correlation

(Continued on Page 16)

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the

aged

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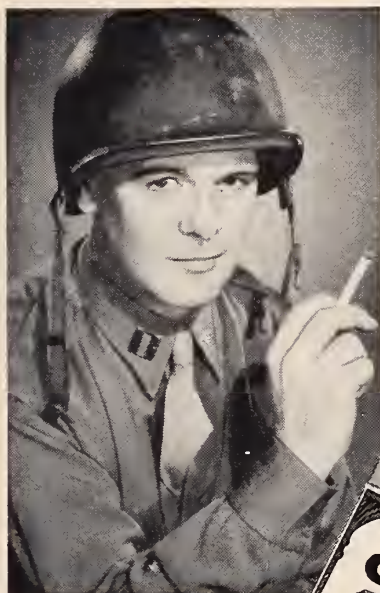
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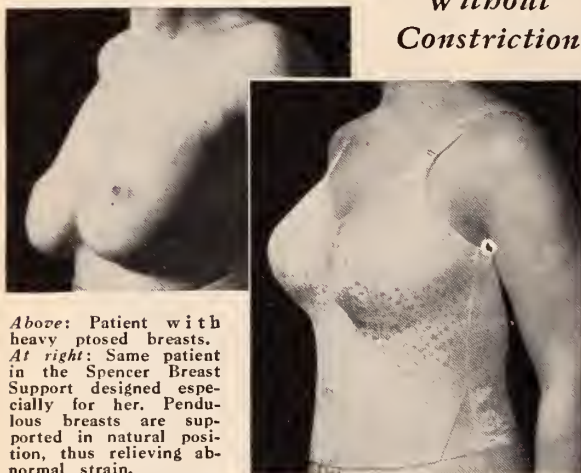
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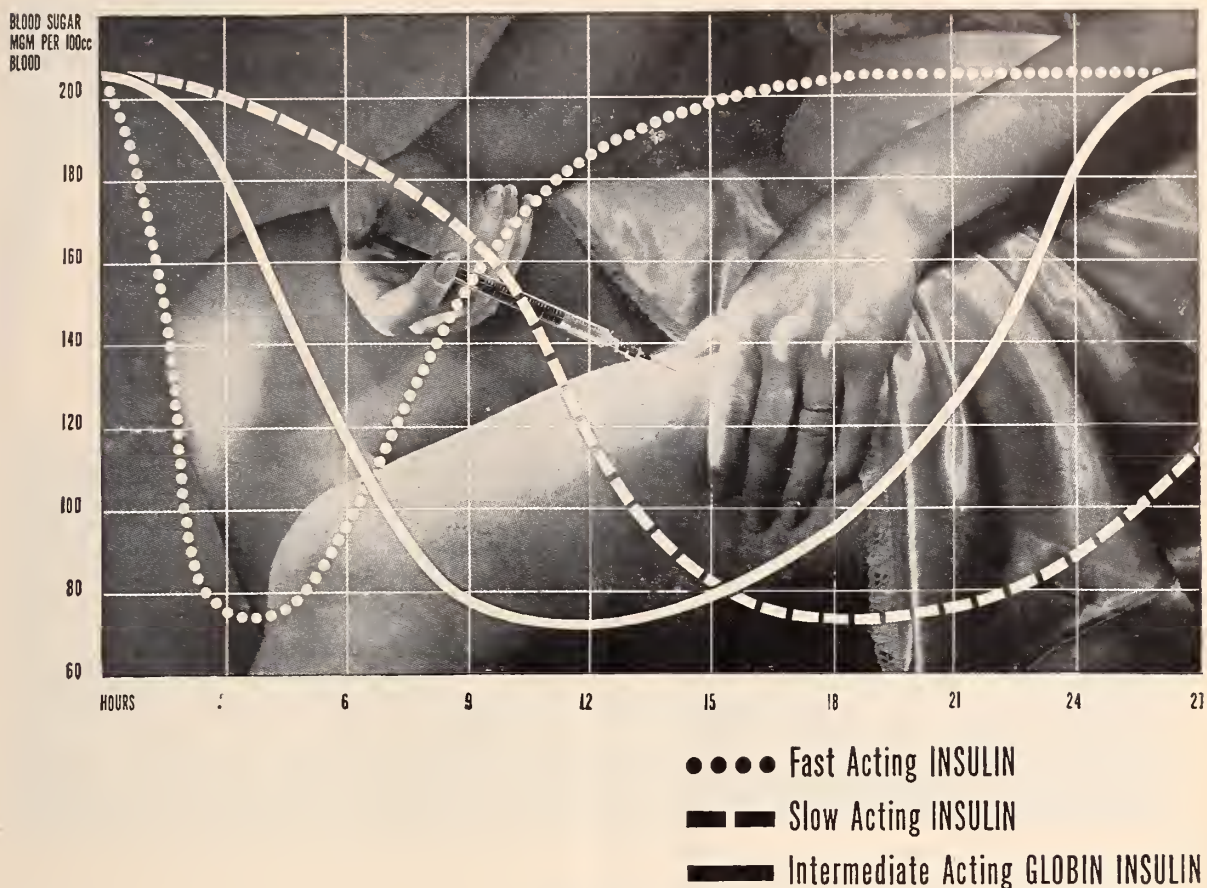
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Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc., and vials of 10 cc., 40 units in 1 cc. Literature on request. 'Wellcome' trademark registered.

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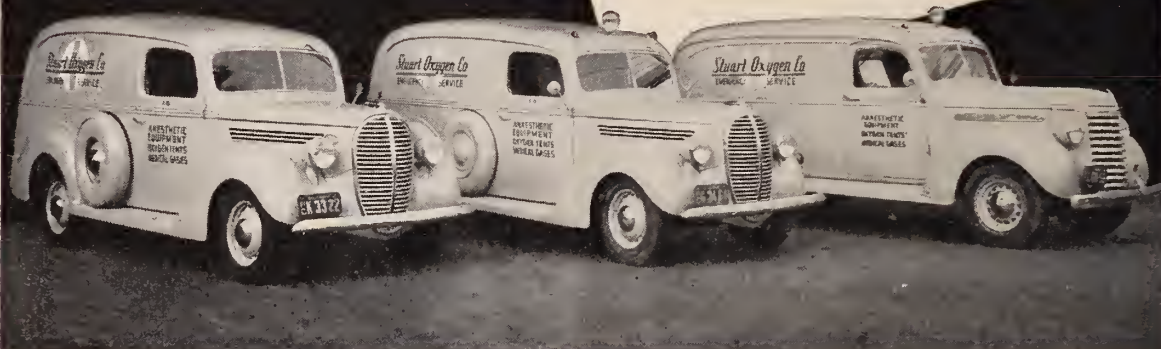


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### BOOK REVIEWS

(Continued from Page 10)

of the pharmacologic action of the various drugs on both maternal and fetal organ structures; (2) the re-evaluation of indicated and contraindicated drug combinations in cases with known maternal or fetal abnormality or disease; (3) the selection of the type of pain relief best suited to the mother's physical and emotional status; and (4) the perfection and simplification of technique through full utilization of the allied basic medical sciences to the end that the greatest possible maternal and fetal welfare may be attained.

**A Synopsis of Medicine.** By Sir Henry Letheby Tidy, K.B.E., M.A., M.D., B.Ch. (Oxon.), F.R.C.P. (Lond.); Extra Physician to H.M. The King; Consulting Physician to St. Thomas's Hospital; Hon. Major-General, lately Consulting Physician to the British Army. Eighth Edition,

Revised and Enlarged. Cloth. Pp. 1215, Baltimore: The Williams and Wilkins Company, 1945.

This book aims at providing a synopsis of such principles of medicine as are of importance at the present time.

A wider scope has been adopted than merely the classification of the most prominent details of each disease. So far as possible the symptoms have been fully enumerated and briefly explained, and the pathology of the disease and references to the most probable or best-known theories have also been included. At the same time it is hoped that, by means of short summaries and special headings, those data which are of greatest importance have been clearly indicated.

The sections on treatment have been planned to afford a ready reference to a reasonable procedure, and no attempt has been made to give numerous alternative

(Continued on Page 17)

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### BOOK REVIEWS

(Continued from Page 16)

methods or prescriptions.

The general arrangement of the book follows that of Osler's universally known *Principles and Practices of Medicine*.

**The Art of Resuscitation.** By Paluel J. Flagg, M.D., Chairman, Committee on Asphyxia, American Medical Association; President and Founder of the Society for the Prevention of Asphyxial Death, Inc.; Director of Pneumatology, New York World's Fair 1939, Inc.; Author, "Art of Anaesthesia"; Visiting Anaesthetist, Manhattan Eye and Ear Hospital; Consulting Anaesthetist to St. Vincent's Hospital, The Woman's Hospital, Sea View Hospital, Jamaica Hospital, Mount Vernon Hospital, Flushing Hospital, Mary Immaculate Hospital, St. Mary's Hospital, and Nassau Hospital. Cloth. Price, \$5.00. Pp. 453, illustrated. New York: Reinhold Publishing Corporation, 1944.

In a foreword to the book, Chevalier Jackson states: Just as I agreed with you many years ago that anaesthesiology must be recognized as an independent department of medical science and clinical work, I quite agree with you now that the time has come for medical schools and hospitals to recognize the fact that Pneumatology is a departmental load that must be taken off the shoulders of the over-burdened anaesthesiologist.

The author stated the purpose of his book is an intensely practical one, being an attempt, based upon more than twenty-five years of intimate experience with the unconscious patient, to tell the reader what to do when faced by an acutely asphyxiated patient about to die. Few conditions in the entire field of medicine calls for more understanding and intelligence, for greater calmness and speed combined with a restrained, precise, but strong technique.

As brought out in the volume, the dramatic and dis-

(Continued on Page 20)

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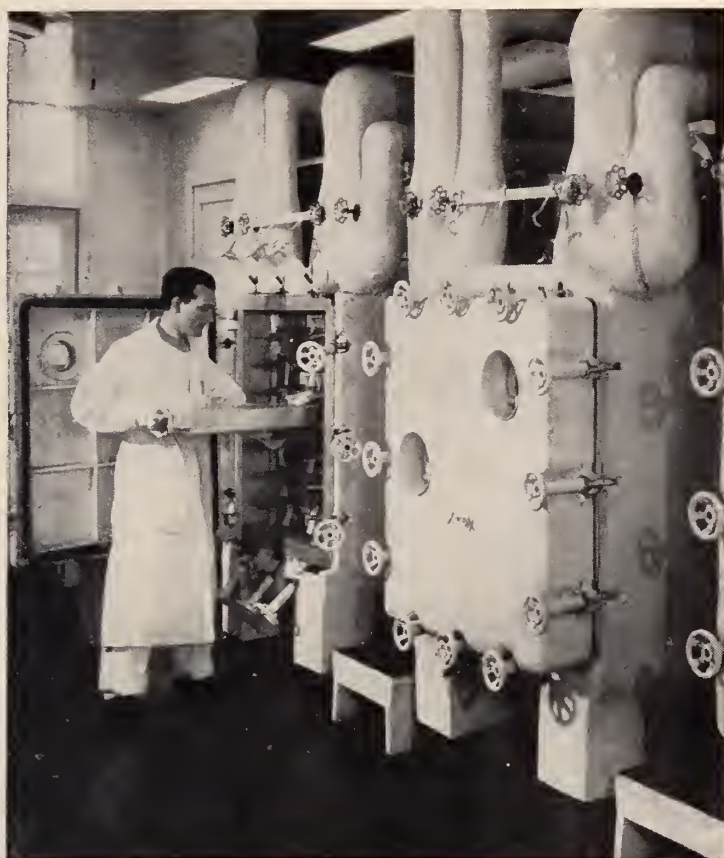
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**1943** Merck Penicillin flown to England for U. S. Army Medical Corps

**1943** Large-scale production of Penicillin was established by Merck to meet Government requirements

**1944** Merck Canadian plant produced first commercial Penicillin by deep-fermentation process in British Empire

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### BOOK REVIEWS

(Continued from Page 17)

turbing environmental factors of the asphyxial accident are due to several causes, i.e., immediate and real danger to life, limited time available for treatment, lack of familiarity with the pathologic physiology involved, ignorance of the appropriate technique to apply in the given case, traditional resistance to instrumentation which may be indicated, routine reliance upon mechanical robots, and despair when these fail.

**Mass Radiography of the Chest.** By Herman E. Hillboe, M.D., Medical Director, Chief, Tuberculosis Control Division, United States Public Health Service; Professorial Lecturer on Tuberculosis Control, George Washington University School of Medicine, Washington, D.C., and Russell H. Morgan, M.D., Surgeon (R), Medical Officer-in-Charge, Radiology Section, Tuberculosis Control Division, United States Public Health Service; Assistant Professor of Roentgenology, Absent on Leave, The University of Chicago. Cloth. Price, \$3.50. Pp. 288, illustrated. Chicago: The Year Book Publishers, Inc., 1945.

In the last decade many workers interested in tuberculosis control and the application of roentgen methods to the early detection of tuberculosis in large population groups have contributed a fund of knowledge on the subject of mass radiography. Although some of this material may be found in the medical literature, the most recent developments have not been reported. The purpose of this book is to bring together this information and to provide a general handbook of mass radiographic methods to assist those who contemplate work in this field.

In the beginning it may have seemed that the problem was an economic one, that the cost of doing the job was the real obstacle to its accomplishment. But chest radiography on 14 x 17 in. paper in long rolls, followed by the development of photofluorography in various sizes from 35 mm. and 70 mm. up to 4 x 5 in. films, soon brought

the operating costs within acceptable limits. The purely economic aspects of mass chest radiography seemed resolved.

At any rate, technical progress has been such that today the chief obstacle to a thoroughly comprehensive, nation-wide program of mass radiography of the chest is to be found on a very different level. As yet unsolved is the problem of getting large numbers of human beings into and through the mass radiographic units.

The authors have written a timely and effective monograph, in which all phases of the subject are considered, each with its proper emphasis.

**Handbook of Industrial Psychology.** By May Smith. Cloth. Price, \$5.00. Pp. 304. New York: Philosophical Library, 1944.

This little book is not intended to be a detailed chronicle of psychology from the industrial standpoint, but to provide an introduction to the subject for those who are in some way responsible for others, or who have to get on with others.

During the last 20 years much patient research has been undertaken to prove the effect of hours of work, of different environments, of selecting people for suitable work, of the cause and control of accidents and various related problems.

Now that all the Armed Forces and some enlightened industrial organizations are applying on a large scale the results of research into human problems of work, others may follow suit. Any scientific work however, even psychology, can be applied mechanically.

**Penicillin Therapy Including Tyrothricin and other Antibiotic Therapy.** By John A. Kolmer, M.S., M.D., Dr.P.H., Sc.D., LL.D., L.H.D., F.A.C.P., Professor of Medicine in the School of Medicine and the School of

(Continued on Page 26)



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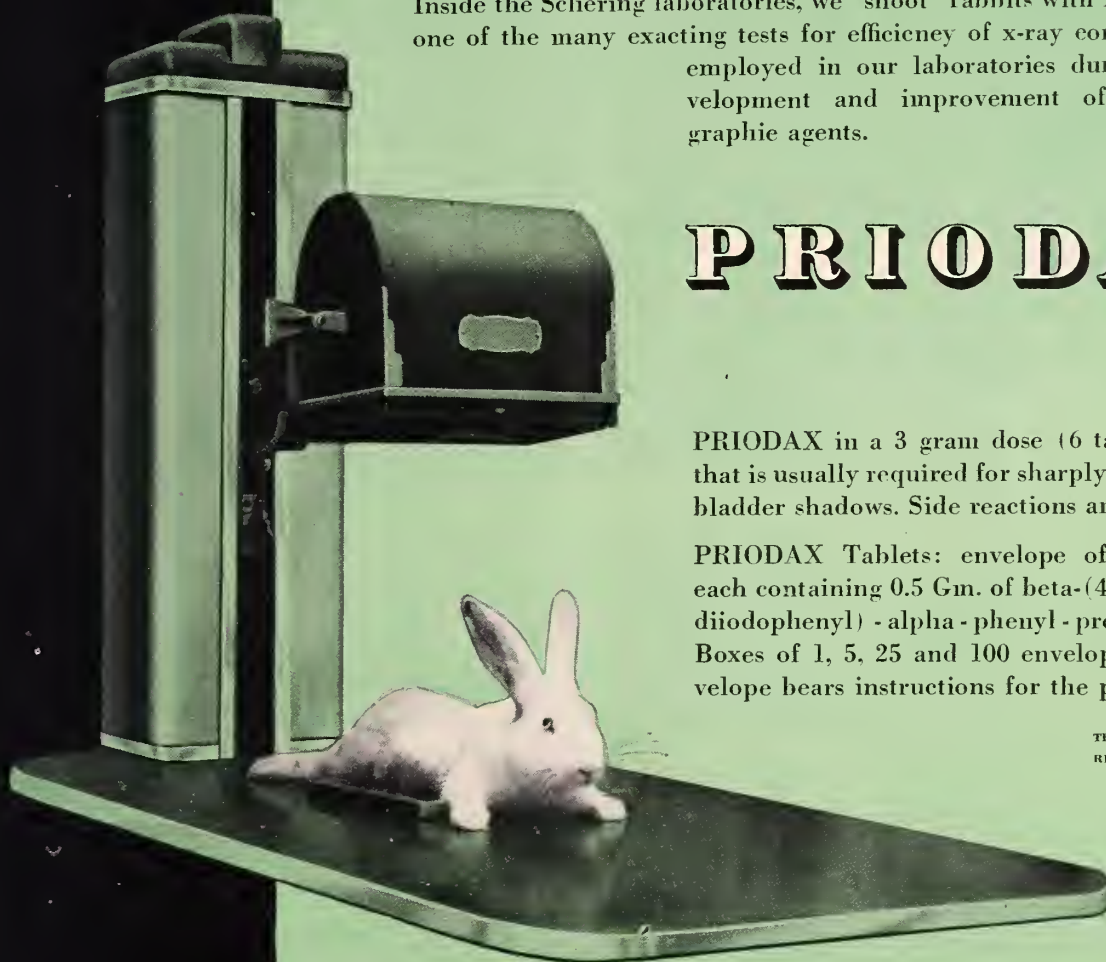
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HERSHEY PHARMACEUTICAL CO.

General Debility, Asthenia  
and Convalescence

30 cc. Vials

GLENDALE, CALIFORNIA

### BOOK REVIEWS

(Continued from Page 20)

Dentistry, Temple University; Director of the Research Institute of Cutaneous Medicine; Formerly Professor of Pathology and Bacteriology, Graduate School of Medicine, University of Pennsylvania. Cloth. Pp. 302. New York, London: A. Appleton-Century Company, Incorporated, 1945.

Four years have now elapsed since Florey and his colleagues first succeeded in isolating penicillin in relatively pure form and discovered its remarkable effects in the treatment of various experimental bacterial infections of mice. During that period American manufacturers have had striking success in its large scale production and purification for treatment purposes.

In that short period of time penicillin therapy has become firmly established as one of the most unique epochs in the history of medicine and chemotherapy. Its development and careful clinical trials will long exemplify the highest traditions in medical research and, incidentally, the rich rewards of sound international coöperation during a war of unparalleled magnitude.

Much is yet to be learned about penicillin in the prevention and treatment of infectious diseases, and especially in relation to its dosage and administration. Kolmer's book aims to give up-to-date and definite information.

### TWENTY-FIVE YEARS AGO

(Continued from Text Page 154)

*Excerpt from Correspondence: Well Deserved Tributes:*  
June 24, 1920.

To the Secretary:

I am enclosing you my check for fifteen dollars, also one-year note for fifteen dollars, covering amount for Indemnity Fund, Medical Society, State of California.

As you of course know by this time, the case of \_\_\_\_\_ terminated favorably for us and I wish to express my thanks to the State Society Defense in this case. I wish especially to show my appreciation of the very painstaking and thorough manner in which Mr. Morrow handled this case. It surely impressed me strongly with the thought that every physician in the State should be a member of this Defense Fund.

Again expressing my appreciation in this matter,  
Believe me,

Fraternally yours,

*Excerpt from County Society Proceedings:*

Los Angeles County Personals.—Dr. Norman Bridge

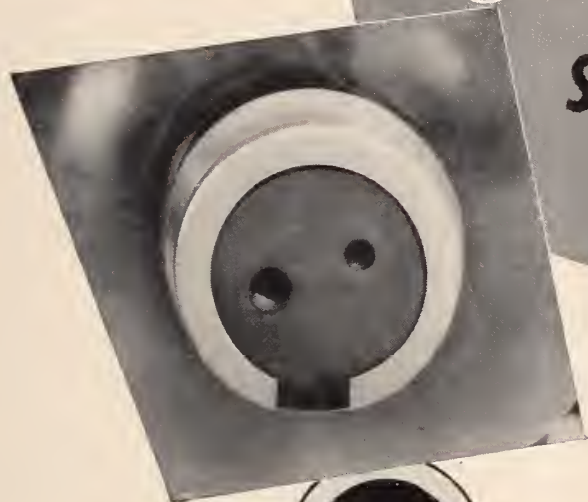
(Continued on Page 26)



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*Hydrotherapy combined with  
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Rates to Fit Any Budget

### TWENTY-FIVE YEARS AGO

(Continued from Page 26)

was reported ill at the Blackstone Hotel in Chicago, July 20th, according to a letter received by Dr. Millbank Johnson, a close friend.

Dr. Lulu H. Peters is now in Albania. During sixteen months of hard work she did not lose a day. She is at Elbassan as a Red Cross medical officer. Besides the clinics, Dr. Peters has charge of the organization of public health work.

In Serbia, the doctor served night and day among the thousands of typhoid cases. In Roumania she did important American relief work and through her the public learned the whereabouts of Queen Marie of Roumania. Dr. Peters next went to the malaria cases in the mountains of Albania. She will remain in Europe until her services are no longer needed in the war-ridden countries of Europe.

Doctors H. Bert Ellis and George H. Kress, Eye, Ear, Nose and Throat, have formed a partnership with offices as heretofore in the Bradbury Building. . . .

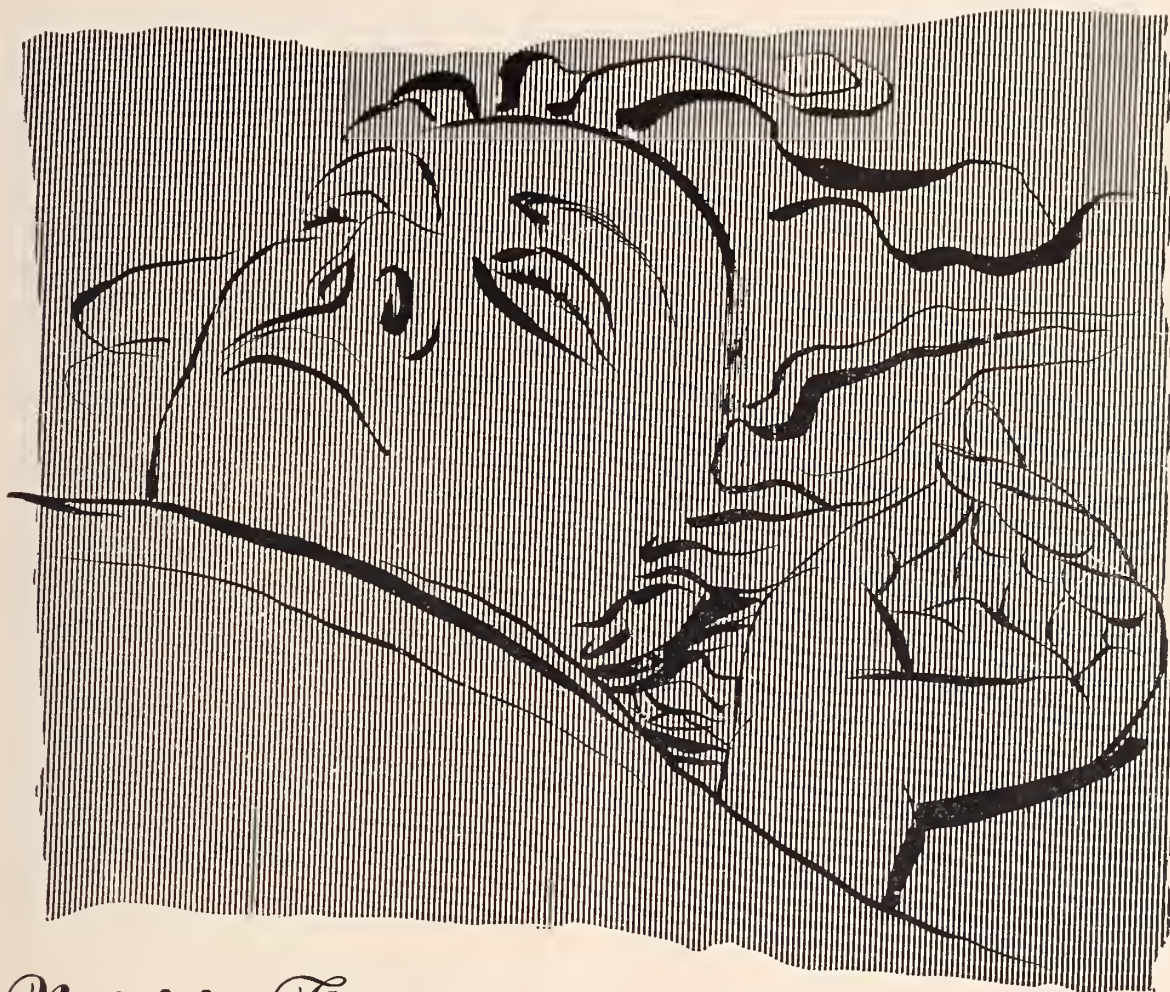
#### *Medicine Before the Bench (Excerpts):*

In this column will appear with appropriate comment, from month to month, court decisions and proceedings affecting the various phases of medical practice, the conduct of hospitals and the enforcement of public health laws.

*Health Officer Upheld in Fight on Social Disease.*—"Vice Isolation of Women Is Given Court Set-back" announce the heavy headlines of several daily newspapers. The story beneath these misleading headlines is based upon a minority opinion rendered by Justice John T.

(Continued on Back Advertising Section, Page 34)





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When the nutritive status of any patient is severely impaired, supportive therapy centers about four essential measures<sup>1</sup>.

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2. Prompt administration of thiamine, riboflavin, niacinamide and ascorbic acid in dosage which clinical experience<sup>1,2</sup> has shown to be effective.
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For further information write to Squibb Professional Service Dept., 745 Fifth Ave., New York 22, N. Y.

(1). Spies, Tom D.; Cogswell, Robert C., and Vilter, Carl: J.A.M.A. (Nov. 18) 1944. Spies, Tom D.: Med. Clin. N. Am. 27:273, 1943. (2). Jolliffe, Norman, and Smith, James J.: Med. Clin. N. Am. 27:567 (March) 1943.

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Consultant in General Medicine

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\*Blotner, H., and Hyde, R. W.: New England J. Med., 229:885, 1943.

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# CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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## California and Western Medicine

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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . . GEORGE H. KRESS, M.D.

### Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

### Committee on Publications

George W. Walker, Chairman.....	Fresno	1946
F. Burton Jones.....	Vallejo	1947
R. H. Sundberg.....	San Diego	1948
George H. Kress, Secretary-Editor.....	San Francisco	ex officio

**Advertisements.**—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

**BUSINESS MANAGER** JOHN HUNTON

Advertising Representative for Northern California

L. J. FLYNN, 544 Market Street, San Francisco (Douglas 0577)

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Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

**Change of Address.**—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

**Responsibility for Statements and Conclusions in Original Articles.**—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

**Contributions—Exclusive Publication.**—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

**Contributions—Length of Articles: Extra Costs.**—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

**Leaflet Regarding Rules of Publication.**—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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## EDITORIALS

### NEXT YEAR'S ANNUAL SESSIONS OF AMERICAN AND CALIFORNIA MEDICAL ASSOCIATIONS

**American Medical Association Is Scheduled to Hold Its 1946 Annual Session in San Francisco.**—At the meeting of the A.M.A. held in 1940, its House of Delegates voted to hold the 1943 meeting in San Francisco. However, transportation difficulties arose and prevented the annual conference in San Francisco in 1943. The House of Delegates then voted to hold the Annual Session of 1946 in San Francisco (the places of an A.M.A. Annual Session are voted on three years in advance).

If ample hotel and meeting room facilities can be made available for the American Medical Association, and provided, transportation difficulties will not interfere, it follows that the 1946 A.M.A. Annual Session should be held in San Francisco.

The C.M.A. headquarters office, in conference with the San Francisco Convention Bureau, the municipal authorities who have charge of the auditoriums in the Civic Center, and the hotel managements, is taking active steps to arrange for all needed facilities of the 1946 A.M.A. meetings in San Francisco.

Already the hotel managements have gone on written record, stating they will place some 3,000 rooms at the disposal of the convention authorities. The City authorities are coöperating to make available the number of auditoriums, section meeting rooms and exhibit spaces that will be needed.

In due course, the time of the A.M.A. Annual Session will be determined by the A.M.A. Trustees.

Newspaper dispatches of September 6, showing President Truman wearing a Shrine fez, indicate that the Mystic Shrine is also arranging for its next national conference in San Francisco. If transportation facilities can be made available to a fraternal and social organization for a large gathering in San Francisco next year, certainly it would appear that a scientific society such as the American Medical Association, many of whose members are still in military service, should be permitted to have transportation accommodations to meetings at which topics of much value and interest in military and civil medicine will be discussed.

Particularly should such permission be granted

as an expression of appreciation to the more than fifty thousand medical officers in Army, Navy, and Air Forces, whose ability and ministrations have made possible the excellent morbidity and mortality rates in World War II, and through whose care the lives of thousands of Americans have been saved.

Unless very good reasons arise for other action, the California Medical Association is holding that the A.M.A. Session will convene in San Francisco, some time during the year 1946.

\* \* \*

Apropos of the above, the C.M.A. Council at its 328th meeting on August 12 took action as indicated in the following minute of proceedings:

*A.M.A. Meeting in San Francisco in 1948:*

Discussion was had concerning the meeting of the American Medical Association which, by vote of the A.M.A. House of Delegates, is scheduled to be held in San Francisco some time during the year 1946. Because of war and transportation conditions, it was deemed advisable to give instructions to the C.M.A. delegates who would represent the California Medical Association at the next meeting of the House of Delegates of the American Medical Association.

On motion made and seconded, the following resolution, to be sent to the Trustees of the American Medical Association and to the House of Delegates of the American Medical Association, was approved:

WHEREAS, The House of Delegates of the American Medical Association in previous annual sessions voted to hold an annual session of the American Medical Association in San Francisco in the year 1943, that decision, because of transportation difficulties incident to World War II, being changed by the A.M.A. Trustees; and

WHEREAS, The A.M.A. House of Delegates subsequently voted that the 1946 annual session of the American Medical Association should be held in San Francisco; and

WHEREAS, Existing transportation difficulties, if war continues, make it more than probable that the A.M.A. Trustees may again be called upon to waive the said decision for the A.M.A. meeting in San Francisco in 1946; and

WHEREAS, The 1947 meeting of the American Medical Association will be held in Atlantic City, the year 1947 being the 100th anniversary of the founding of the American Medical Association; and

WHEREAS, It would be proper that the twice-made decision of the House of Delegates to hold an annual session of the American Medical Association in San Francisco be reaffirmed; now therefore be it

*Resolved*, That the Council of the California Medical Association respectively petitions the Trustees of the American Medical Association and the House of Delegates of the American Medical Association to vote to hold the 1948 annual session of the American Medical Association in the City of San Francisco, (if continuation of World War II makes a meeting in San Francisco in year 1946 impossible); and be it further

*Resolved*, That copies of these resolutions be sent to the Secretary of the American Medical Association for transmittal respectively to the Trustees of the A.M.A. and the House of Delegates of the A.M.A.; and be it further

*Resolved*, That the eight delegates representing the California Medical Association in the House of Delegates of the American Medical Association be instructed to make the proper presentation to the A.M.A. Trustees and to the A.M.A. House of Delegates.

And here the matter rests at date of this writing.

\* \* \*

**California Medical Association Will Hold Its 75th Annual Session in Los Angeles in Year 1946.**—At this year's annual session of the California Medical Association, held in May last, its House of Delegates accepted the Council's recommendation that next year's annual meetings be held in Los Angeles. Days of the conference (whether for a two, three or four day ses-

sion) will be decided by the Council at a later date. The dates of meetings will depend somewhat upon the time of meeting of the American Medical Association. The C.M.A. Council will aim to arrange the dates in a manner to promote the interests of the national as well as the state gatherings.

\* \* \*

In the meantime, members of the California Medical Association,—and this applies to members in military as well as those in civilian practice—are cordially invited to send suggestions of topics for scientific programs for C.M.A.'s thirteen scientific sections, or to submit to section officers, either through Section Secretaries, or through the Association Secretary (who is the chairman of the Committee on Scientific Work), titles of papers covering work or subjects in which they may have special interest. If such co-operation is given, assurance of good scientific programs may be guaranteed. The roster of officers of scientific sections, with addresses, appears in CALIFORNIA AND WESTERN MEDICINE, every second month or so, usually in the front section on page 4. Members who are in position to participate in next year's annual session program should write promptly to the Secretary of the proper Section.

In due time, additional information will be given concerning the A.M.A. and C.M.A. annual sessions of 1946.

#### ON POSTWAR EDUCATIONAL FACILITIES FOR MILITARY COLLEAGUES

**Problems Confronting Military Colleagues on Their Return to Civil Practice.**—Now that VE and VJ days have come and gone, many physicians who are among the 60,000 or so who are in service with the Armed Forces are giving serious thought to plans on what they will do when they are released from military duty.

Older physicians, nearly all of whom have family dependents and responsibilities will naturally wish to reestablish themselves as promptly as possible in either the community in which they practiced before entering the Army or Navy, or perhaps in some newer or more rapidly growing district. Of these, nearly all, provided adequate educational facilities are made conveniently available, would prefer to take short or longer refresher or similar courses dealing with medicine, surgery, pediatrics, obstetrics and allied branches.

The four Class A medical schools of California—University of California Medical School, Stanford University School of Medicine, University of Southern California School of Medicine, and College of Medical Evangelists, have here a definite responsibility, since many of the 2,000 military members of the California Medical Association will instinctively turn first to these institutions to ask what postwar refresher or other courses are being offered, particularly for general practitioners. The hope is expressed that the executive boards of the four California Medical Schools will carry on conferences through which



plans will be put in operation that will permit a considerable choice of work.

Older military colleagues who may be thinking of limiting their professional work to one of the specialties will probably seek facilities for such training in Eastern Medical Centers.

For younger physicians, whose professional training as interns or residents may have been interrupted by induction into military service, the accredited and approved hospitals located in California and other States will probably present good opportunities for continuation of general or special training.

Physicians in military service who contemplate refresher, special, or other courses will find much information in the special numbers of the *Journal of the American Medical Association* (Index, Hospital, State Board and Educational numbers. Also, *J.A.M.A.* issue of July 7, 1945, on page 751).

In the *J.A.M.A.* issue of September 1, 1945, excellent articles of informative nature appear: Educational Facilities for Physician Veterans, p. 28; Plan in North Carolina, p. 33; Review and Refresher Courses, p. 34, and others. Valuable time will be saved through perusal of the up-to-date information therein presented. Medical officers who contemplate refresher, continuation, or courses in the specialties, or internships or residencies should not fail to secure a copy of this issue which, if not otherwise available, may be had for loan by writing to one or more of the three medical libraries in California, addresses of which are given on page 5 in the front section of each issue of CALIFORNIA AND WESTERN MEDICINE.

Concerning the G. I. Bill of Rights in relation to medical officers, an excerpt from Dean Wilburt C. Davidson's article in *J.A.M.A.*, for September 1, 1945, on page 33, is here given:

All veterans, regardless of the age at which they entered the service and whether or not they had been in practice, are eligible under the G. I. Bill of Rights for a retraining course of one year at any institution approved by the Veterans Administration, which will pay fees to the institution up to \$500 per year and a subsistence allowance of \$50 monthly to the veteran; \$75 if he has a dependent. On completion of this one year course, veterans who entered the service under 25 years of age and those, regardless of age, who can show that their training was impeded or interrupted by their entrance into the service also are entitled to additional training of the same number of months they have been in the service. In other words, a medical officer who has been in the armed forces for thirty months and entered the service at the age of 25 years or, regardless of age, had been an intern or resident but had not completed his resident training is eligible for three and one-half years of postwar training, i.e., one year, plus thirty months.

The central office of the California Medical Association, 450 Sutter, San Francisco (8), will be happy to render possible service to C.M.A. members and others who seek additional information.

We have room in this country for but one flag, the Stars and Stripes. . . . We have room for but one loyalty, loyalty to the United States. . . . We have room for but one language, the English language.

—Theodore Roosevelt, *The Great Adventure*. Also last message to the American Defense Society, 3 January, 1919, two days before his death.

## BENEVOLENCE FUNDS TO AID IN CARE OF NEEDY PHYSICIANS AND THEIR DEPENDENTS: WHAT CALIFORNIA MEDICAL ASSOCIATION AND LOS ANGELES COUNTY MEDICAL ASSOCIATION ARE DOING

**C.M.A. Physicians' Benevolence Fund.**—Again and again, worthwhile objectives must bide their time before getting a start on the road to real fulfillment. Of such may be mentioned endeavors to formulate plans for, and to set up actively working organizations, through which elderly physicians who have met with financial or other reverses could receive aid from members of their profession, thus making possible at least a partial alleviation in their distress and sufferings.

Over many years, the proceedings of constituted authorities of a goodly number of state and component county medical societies have outlined plans for benevolent purposes, but the well meant endeavors only too often have not gotten beyond the laudable resolutions dealing with the subject.

It is gratifying, therefore, to call attention to the progress that has been made during the last few years by the California and Los Angeles Medical Associations, in developing their own benevolent activities.

First, some comments may be in order concerning the "Physicians' Benevolence Fund of the California Medical Association" (referred to in C.M.A. Constitution under Article XI, Section 1, and in By-laws in Chapter V, Section 23). That C.M.A. fund on December 31, 1944, as per Treasurer's report in April, 1945 CALIFORNIA AND WESTERN MEDICINE, p. 208, was credited with assets of \$13,945.38; and each year, as provided in the C.M.A. Constitution:

At least \$1.00 out of the annual dues paid by each member of the Association shall be allocated to the Physicians' Benevolence Fund and shall only be used for the purposes as set forth in the By-Laws.

At the 328th meeting of the C.M.A. Council, held on August 12, 1945, report was made by the C.M.A. Physicians' Benevolence Committee as follows:

### C.M.A. Physicians' Benevolence Committee:

Councilor Axel E. Anderson, Chairman of the C.M.A. Physicians' Benevolence Committee, made report concerning the work of the committee, with special reference to the conditions in Los Angeles County, where some 93 individuals receive aid, more than one-half being widows of physicians. In Los Angeles, with the aid of the Los Angeles County Medical Association, the monthly outlay is something like \$800. After discussion, the Council voted to approve the committee's recommendation that the allocation to Los Angeles County from the C.M.A. Benevolence Fund be increased from \$300 to \$500 per month.

Chairman Anderson also called attention to the campaign which had been inaugurated by the Los Angeles County Medical Association to build up an independent Benevolence Fund, stating that to date in that county the sum of \$150,000 had been secured for such objective, the campaign to raise a fund of \$500,000 for that county still going on.

The efforts to establish the Physicians' Benevolence Fund of the California Medical Association began in the annual session held at Del Monte, in May, 1939 (Resolution No. 11), being followed

through with adoption of a proper By-Law at the 37th annual meeting of the House of Delegates in May, 1940, held at Coronado. The original committee consisting of Doctor A. E. Anderson, of Fresno, Chairman, with Doctors Elizabeth M. Hohl, Los Angeles, and Doctor Robert A. Peers, of Colfax, continues to supervise the C.M.A. benevolence work.

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**"Physicians' Aid Association of the Los Angeles County Medical Association."**—Such is the name of the nonprofit corporation, sponsored by the Los Angeles County Medical Association, and organized under California law. This organization is the successor of a special committee of that component county unit that started its active work in 1937. It is chartered as a nonprofit corporation under date of March 14, 1940. Its voting membership is limited to those members of the Los Angeles County Medical Association who contribute to its maintenance (Annual Membership at \$5.00 per year; Life Membership through a payment of \$50.00; Benefactor Membership through a payment of \$100.00; and Special Benefactor, through a payment of \$1,000.00 or more). During the last two years this subsidiary of the Los Angeles County Medical Association has been able to collect more than \$150,000.00 in cash toward the attainment of its goal of a fund of \$500,000.00. Truly, a laudable ambition and a commendable accomplishment to date.

It is questionable whether the benevolent projects initiated elsewhere in the past (Pennsylvania, New York, Illinois) can present a better record for so brief a period. The endeavors to bring into existence the sum of \$500,000.00 are still being actively promoted in Los Angeles, and much credit is due the officers of the Los Angeles County Medical Association and the nonprofit corporation for the excellent results thus far achieved.

Contributions have been received from others than physicians, the Woman's Auxiliary to the Los Angeles County Medical Association having donated \$3,722.93. Druggists, Medical Building Corporations; Insurance Groups, and Individuals have all made donations to the Physicians' Aid Association.

It is of interest to note that the U. S. Commissioner of Internal Revenue has included the Los Angeles County Physicians' Aid Association in the listing of organizations, whereby those who give to the accepted organizations are permitted to deduct such gifts from the Donor's income in the computation of Federal Income Tax. Thus, if a physician found himself in the 50 per cent tax bracket and gave \$1,000 to the Los Angeles Physicians' Aid Association, he would be permitted to deduct \$500.00.

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**Bequest Forms of the California and Los Angeles Benevolence Funds.**—Several years ago, CALIFORNIA AND WESTERN MEDICINE, from time to time printed some legal forms to serve as

suggestive guides for any physicians who might desire to leave bequests to the C.M.A. Benevolence Fund. The same forms would be applicable to the Los Angeles County Physicians' Aid Association through insertion of that name. These forms are here inserted to complete these comments, the hope being expressed that members of the California Medical Association who may have been blessed with ample financial resources may wish to add to their happiness on earth by setting aside certain sums or properties to aid in carrying on the commendable activities above discussed. What better monument than to leave one's name on record for those who are yet to come, than through such a contribution to our beloved profession and to worthy disciples and their dependents, who may have met with misfortune?

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#### **(A) Bequest Forms for the "Physicians' Benevolence Fund of the California Medical Association"**

##### *Form of Clause of Will Providing for Cash Bequest*

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of \$\_\_\_\_\_ for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association.

\* \* \*

##### *Form of Clause of Will Providing for Cash Bequest*

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of \$\_\_\_\_\_, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be paid to and become a part— of the Physicians' Benevolence Fund of the California Medical Association as said fund is established and maintained by said Association.

\* \* \*

##### *Form of Clause of Will Providing for Bequest of Personal Property*

I hereby give and bequeath unto the Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be expended by said corporation for the benefit and as a part of the Physicians' Benevolence Fund of the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

\* \* \*

##### *Form of Clause of Will Providing for Devise of Real Property*

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California, for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association the following described real property situate in the County of \_\_\_\_\_ State of California, and more particularly described as follows, to-wit:

\* \* \*

##### *Form of Clause of Will Providing for Devise of Real Property*

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be held as a part of the Physicians' Benevolence Fund of the California Medical Association, the income whereof shall be used for the purposes of said fund as it is established and maintained by the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.



## (B) Bequest Forms for the "Los Angeles County Physicians' Aid Association"

Excerpts from By-Laws of Aid Association of Los Angeles County Medical Association follows:

### ARTICLE XI

#### Forms of Bequest

##### Section 1. Form of a Devise.

I, \_\_\_\_\_ of \_\_\_\_\_ do hereby devise and bequeath to the Los Angeles County Physicians' Aid Association, their successors and assigns, all that—

(Here recite the real estate from the deed)

##### Section 2. Form of a Donation or Bequest.

I, \_\_\_\_\_ of \_\_\_\_\_ hereby give and bequeath unto the Los Angeles County Physicians' Aid Association the sum of—

Note—By the laws of California all bequests of a charitable character must be made at least one calendar month before the death of the donor, and the will must be attested by two disinterested witnesses.

## WHY DID P.T.A. SUPPORT COMPULSORY HEALTH INSURANCE?\*

Misguided efforts to lift the lid on the Pandora's box of state medicine have too frequently been abetted by sincere, worthwhile organizations. More than one prominent group laudably interested in better health care, but unaware of the many dangers to sound medical progress involved, has succumbed to glib suggestions that compulsory health insurance is the panacea for all ills.

A case in point is the California Congress of Parents and Teachers. No California organization has a more distinguished record of solid achievement in its own field. No one questions its wisdom, its competence or its high aims in striving for educational progress. But Parent-Teacher advocacy of compulsory health insurance at the 1945 Legislature marked a radical change in P.T.A. program, something foreign to its traditional purposes.

It is obvious that the P.T.A. must concern itself with the health of California's school children. Its success in meeting this responsibility is amply demonstrated by the well-baby clinics, health roundups and dental inspections developed in full cooperation with medical and allied services. But just how the organization spanned the gap between child health care and endorsement of socialized medicine is shrouded in obscurity.

Published statements do little to dispel the uncertainty. The president of the P.T.A. Congress, in a letter recently addressed to a San Francisco newspaper, declared, "The Congress feels that the child has a right to medical and dental care and periodic check-ups on his general health until he is old enough to take care of himself." Such statements ring pleasantly in the ears of parents and the public, because everyone knows more medical attention would be good for every child. However, they ignore the fact that state medicine could not of itself produce more care for children or anyone else.

Again in the words of the P.T.A.: "Unless parents are *compelled by law* to give their children regular medical and dental care, vast numbers of childhood ailments, such as defective

sight, hearing, poor posture, low nutrition, bad tonsils, huge adenoids, defective teeth, rheumatic fever, TB tendencies and other ills, will continue to haunt the path of childhood!" There's something stupendous about the long list of ailments which compulsory health insurance is expected to cure or allay—but the old fallacy that bureaucratic medicine will mean perfect health for everyone is still apparent.

The P.T.A. adds a new note, though, which has some nice goose-stepping possibilities. *Compel the patient to go to the doctor!* Not even the most ingenious drafter of a health insurance bill as yet has tried that idea in any scheme. At worst, he has stopped with the attempt to cajole, coerce or bully medicine into providing regimented service, and to tax wage-earners for the privilege of standing in line in front of doctors' offices.

That any important civic organization could earnestly support compulsory health insurance, as the P.T.A. president maintains, solely for the reasons quoted, is evidence enough that medicine is perilously close to losing its battle to survive as a profession. The challenge is unmistakable.

## EDITORIAL COMMENT †

### NUTRITIONAL CONTROL OF CANCER

About ten years ago it was suggested by Brody<sup>1</sup> of the University of Missouri that the increased incidence of cancer during recent decades is due to the over-nutrition and under-exercise characteristic of modern civilization. Tannenbaum<sup>2</sup> confirmed this hypothesis. He found that in both man and animals there is a positive correlation between the incidence of cancer and body weight, and suggested that the establishment and maintenance of lower average weight levels is worthy of trial in the prevention of human cancer.

Experimental tests of this method were made by Rusch<sup>3</sup> and Potter<sup>4</sup> of the McCordle Memorial Laboratory for Cancer Research, University of Wisconsin. In a typical experiment 192 young adult mice received exactly the same amount of protein, salts and vitamins. Half of them were given a high carbohydrate supplement. The total diet of this group was 9.6 calories per day. This is 50 per cent more than is required to maintain weight. The other half of the mice were given only a sufficient supplement to maintain body weight, their total food intake being 6.4 calories per day. All mice received a standard minimal dose of cancer-producing ultraviolet light for 30 minutes every other day. By the end of 9 months 88 per cent of the high-caloric group had developed cancer. There was only a 2 per cent incidence of cancer in the low-caloric group.

The low-caloric mice received a great deal of

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

\* A contributed article.

exercise, since they were constantly in motion. The high-caloric mice received almost no exercise and were quite indolent. From these and other data Potter concluded that when animals are placed under conditions analogous to those of modern civilized man the incidence of cancer is increased. He believes that this is a definite guide to the prevention of cancer in man. He emphasizes, however, that restrictions in the quantity of food eaten requires that the quality of the food be carefully controlled.

This conclusion is challenged by Morris<sup>5</sup> of the National Cancer Institute, Bethesda, Md., who has collected and summarized all pertinent data reported by earlier investigators. All of the experiments summarized by him were made on pure strain mice whose average normal percentage of spontaneous mammary cancer varied from 36 to 80 per cent with different strains. The type of underfeeding was usually a one-third to one-half reduction in total food or caloric intake, or a similar reduction in certain essential food elements, such as lysine or cystine. Under these food deficiencies the percentage of spontaneous mammary cancer was reduced on an average to from 3 to 18 per cent for the different strains.

The mice selected were usually young adults. Under adequate control feeding these mice increased from 50 to 100 per cent in body weight during the course of the experiment (18 to 28 months.) In the deficiency groups the body weight usually decreased as much as 25 to 45 per cent before the end of the experiment. In many mice the deficiency diet resulted in a complete absence of estrus and atrophy or infantilism of the mammary glands, to which the reduced incidence of cancer was presumably due. Morris concludes that dietary regimens thus far known or assumed to inhibit or delay carcinoma development in animals are too drastic to be of practical value as a means of preventing human cancer.

The rôle of exercise upon cancer development was studied by Kline and Rusch.<sup>6</sup> They report that forced exercise slows the rate of growth of transplanted sarcoma in mice. Morris regarded this conclusion as unwarranted due to the concomitant lowered food intake of the exercised animals.

In Morris' opinion no broad generalization as to the effect of nutrition or exercise in the prevention of human cancer should be made at this time.

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#### REFERENCES

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3. Rusch, H. P., *Physiol. Rev.*, 24:177, 1944.
4. Potter, V. R., *Science*, 101:105 (Feb. 2), 1945.
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Sometimes people call me an idealist. Well, that is the way I know I am an American. America is the only idealistic nation in the world.

—Woodrow Wilson, *Speech*, Sioux Falls, S. D., 8 Sept., 1919.

## NUTRITIONAL VALUE OF SUNFLOWER SEED

In search for new food materials of significant value in human and animal nutrition, Day and Levin<sup>1</sup> of the Department of Chemistry, Indiana University, made quantitative studies of the relative nutritional value (vitamin content) of sunflower seed meal, as compared with similar products from wheat, corn, and soybeans. Since there is marked vitamin destruction by the severe heat treatment incidental to pressure extraction of sunflower seed oil, Day and Levin limited their tests to sunflower seed meal resulting from low temperature solvent extraction. Weanling rats were divided into different groups with due regard to litter membership, sex and weight. Each group was fed the same basic ration plus 5 to 10 per cent of the product to be tested, this product being the sole source of vitamin B complex. The supplements were: defatted wheat-germ meal, defatted corn-germ meal, defatted sunflower seed meal, defatted soybean meal, and Brewer's yeast (control). The growth rate was least rapid with soybean meal. The 5 per cent soybean group gained in weight an average of but 21 grams per rat by the end of 7 weeks. Wheat germ and corn germ meals gave an average gain of 46.5 grams per rat. Sunflower seed meal was superior to both wheat and corn germ meal (three times superior to soybean meal), giving an average gain in weight of 56 grams per rat by the end of the same period of time. By the end of 14 weeks, the average gain was 70 grams per rat with 5 per cent wheat and corn germ meals and 70 per cent greater, or 119 grams per rat, with the sunflower seed meal. Day describes the sunflower seed meal as a light gray palatable powder (53 per cent protein) which can be satisfactorily blended with wheat flour or corn meal to make appetizing baked foods. Its high nutritional properties (vitamin content) suggests that sunflower seed may be of much more practical value in human nutrition than hitherto assumed.

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1. Day, H. G., and Levin, E., *Science*, 101:438 (Apr. 27), 1945.

*Jacksonian Epilepsy.*—The present-day conception of epilepsy is based on the studies of John Hughlings Jackson, unilateral or Jacksonian epilepsy having been described in 1875. It may likewise be said that there remains little to be added today to the observations Jackson made upon the subject of eyesight and tabes. Among other valuable studies there was the one on aphasia in 1864; and in 1898 he originated the doctrine of "levels" in the nervous system.—Warner's *Calendar of Medical History*.

There can be no fifty-fifty Americanism in this country. There is room here for only 100 per cent Americanism, only for those who are Americans and nothing else.

—Theodore Roosevelt, *Speech*, Republican Convention, Saratoga.



## ORIGINAL ARTICLES

## Scientific and General

## RECENT OBSERVATIONS ON VIRUS PNEUMONIA\*

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WHEN the etiology of the group of diseases called virus pneumonia was discussed before the California Medical Association three years ago<sup>1</sup> a causative virus was demonstrable in not more than 10 per cent of cases. Since then a new virus, which is believed to be the etiologic agent in the prevalent form of primary atypical pneumonia, has been isolated,<sup>2</sup> and several other agents have been described as possibly associated with pneumonia in man, among them two viruses causing pneumonia in cats,<sup>3,4</sup> an agent infectious for guinea pigs,<sup>5</sup> and an indifferent streptococcus.<sup>6</sup> It is not possible to evaluate, on the basis of present evidence, the importance of the latter agents as a primary cause of pneumonia in man, and time does not permit a detailed discussion of the claims advanced for them by the various investigators.

## CLASSIFICATION

A preliminary classification of virus pneumonias based on etiology is presented in Table 1. Those most thoroughly studied include primary atypical pneumonia caused by a virus transmitted in our laboratory to chick embryos, cotton rats, and hamsters, virus pneumonias caused by the psittacosis group of agents, and influenzal pneumonias due to influenza virus type A or B. There are important epidemiological and clinical differences between these three diseases.

Evidence to be presented later indicates that about 60 per cent of the cases of virus pneumonia are caused by the new virus. It is suggested that the term "primary atypical pneumonia" be reserved for this prevalent form of the disease or etiologic entity caused by a single virus. The diagnosis of psittacosis virus pneumonia, influenza virus pneumonia, or bronchopneumonia of unknown etiology should be applied to distinguish these diseases from primary atypical pneumonia. The disease called primary atypical pneumonia may occur as sporadic cases, in family or institutional outbreaks, or as small epidemics. Presumably the agent is transmitted from person to person by contact or droplet infection, as no reservoir other than man has been found. Primary atypical pneumonia is usually a mild illness, although severe or fatal cases are sometimes caused by the same virus. The mortality is generally stated to be less than 1 per cent.

Viruses of the psittacosis group are distinct from the agent which causes primary atypical pneumonia and are responsible for only a small proportion, probably less than 10 per cent, of all cases of virus pneumonia.<sup>1</sup> The psittacosis-like viruses are carried by birds of the parrot family, chickens, and pigeons, and have also been found in cats, mice, and ferrets. Pneumonia of the psittacosis group is usually produced in man by inhalation of the dried excreta of birds or by contact with infected tissues. Transmission from human cases is relatively rare, but may occur in nursing contacts. The disease is more severe than the prevalent form of atypical pneumonia, and the

case fatality is high. The virus is quite readily isolated from the sputum or lung tissue by direct inoculation of mice or cotton rats.

The term "influenzal pneumonia" includes not only all degrees of pulmonary involvement from mild bronchitis to severe fulminating pneumonia caused by type A or B influenza virus, but also secondary bacterial pneumonias following influenza. This disease occurs only during influenza epidemics. The influenza virus has never been isolated from sporadic cases of virus pneumonia. The case fatality is variable, depending in part on the virulence of the virus causing the epidemic, but in recent years the mortality among patients with influenzal pneumonia can be placed with some certainty below 10 per cent.

The virus of lymphocytic choriomeningitis and the rickettsiae of Q-fever are known to produce a disease which sometimes resembles virus pneumonia,<sup>7,8</sup> but there is at present no evidence that these agents cause many cases of this illness. In 30 per cent or more of patients with the clinical signs and symptoms of virus pneumonia no etiologic agent has been demonstrated. Possibly some of these illnesses are bronchopneumonias caused by bacteria, and it should be remembered that in the early phases of coccidioidomycosis a disease resembling primary atypical pneumonia may occur. It is also possible that some of the other viruses which have been described may cause these pneumonias, which are at present of unknown etiology.

## ETIOLOGY OF PRIMARY ATYPICAL PNEUMONIA

*Isolation of virus.*—Two methods of isolating the causative virus of the prevalent form of atypical pneumonia are outlined in Table 2. The "orthodox" method shown in the upper part of the table was unsuccessful. Although definite pulmonary lesions were obtained in cotton rats and hamsters after primary intranasal inoculation of sputum, only small or irregular lesions or none at all appeared on further passage. In certain series, lesions were obtained consistently in the later passages, indicating an adaptation of the virus, but these differed grossly and microscopically from the pulmonary infiltration obtained with the original sputum. The agent producing these lesions was not neutralizable by human convalescent serum, and further investigation showed that the lesions were probably due to a contaminating virus from the cotton rats. A new procedure, as shown in the lower part of Table 2, was then adopted and this method was more successful for isolation of the virus. Suspensions of sputums were filtered through bacteria-retaining collodion membranes, and the sterile filtrates were inoculated into the amnion of 12-day-old chick embryos. On serial passage in chick embryos adaptation of the virus from human material was accomplished in 5 of 10 trials. One strain was isolated from a bacteriologically sterile sample of human lung. As the chick embryos showed little significant pathology it was necessary to inoculate hamsters and cotton rats intranasally with the chick embryo material to demonstrate the presence of the virus. This procedure produced in 25 to 75 per cent of the animals pulmonary lesions which appeared, on gross and microscopic examination, to be almost identical with those resulting from inoculation of sputum.

*Serological reactions.*—Clinical and laboratory data on four cases of atypical pneumonia are presented in Table 3. These cases were relatively mild, and the white blood cell counts were normal or low. Two cotton rats inoculated with sputum from patients 1 and 2 respectively, both developed pulmonary lesions; and lesions were found in one of four animals inoculated with sputum from the fourth patient.

In a certain proportion of cases of primary atypical

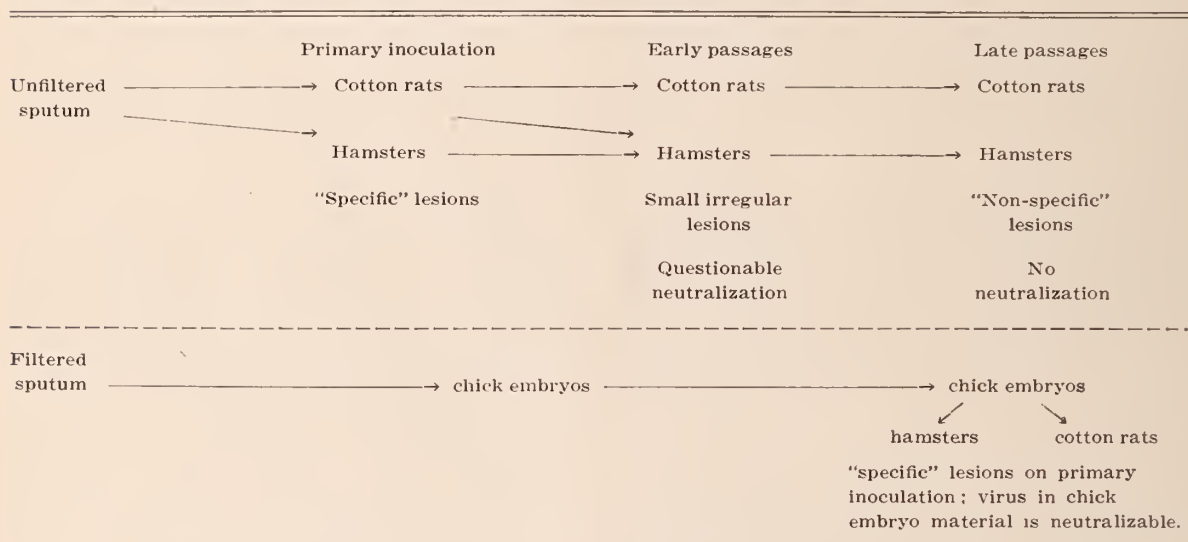
\* Read before the Section on Public Health, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

From the Research Laboratory of the California State Department of Public Health.

TABLE 1.—*Classification of Virus Pneumonias*

	Estimated proportion of all cases	Epidemicity	Source	Clinical course	Case fatality	Virus isolation in
	Per Cent				Per Cent	
Primary atypical	60	sporadic or epidemic	man	usually mild	less than 1	chick embryos cotton rats hamsters mice
Psittacosis group	< 10	usually sporadic	birds	very severe	over 20	cotton rats
Influenza A or B	< 10	epidemic	man	moderately severe	less than 10	chick embryos ferrets hamsters
Lymph. chorio-meningitis	?	sporadic	rodents	severe	—	guinea pigs mice
Q-fever	?	—	ticks	moderately severe	about 5*	guinea pigs
Unknown etiology	30	sporadic ?epidemic	(resemble other virus pneumonias)			—

\* Based on 15 laboratory infections at the National Institute of Health.<sup>8</sup>

TABLE 2.—*Methods of Isolating the Virus of Atypical Pneumonia*TABLE 3.—*Clinical and Laboratory Data in Four Mild Cases of Primary Atypical Pneumonia*

	Fever maximum duration	Pulmonary lesion	Day of illness	White blood cell count	Sputum (cotton rat)	Serological titers		
						Cold agglutination	Streptococcal agglutination	Neutralization
Ir	104. 9 days	RLL	4	5,800	2/2	—	0	< 2
			32	9,600	—	—	10	8
			92	—	—	—	0	< 4
Sn	104. 10 days	RLL	4	4,950	2/2	10	0	< 4
			8	—	—	80	0	< 8
			14	—	—	320	0	16
So	102. 8 days	LLL (min.)	5	11,800	—	20	—	< 2
			10	8,200	—	320	0	8
			17	—	—	160	0	32
McN	101. 7 days	RUL	25	—	—	80	0	32
			3	7,500	1/4	10	0	4
			17	10,400	—	10	0	128

pneumonia the serum develops between the 10th and 20th day the property of agglutinating type O human erythrocytes at low temperatures.<sup>9</sup> This cold agglutination reaction disappears in the patient after convalescence and also after storage of the serum itself for periods of a month or more. Cold agglutination has been observed in other diseases, and we have found it in three cases of influenzal pneumonia. Although this reaction is not entirely specific for primary atypical pneumonia, the presence of the cold agglutinins in titers above 20 asso-

ciated with pneumonia offers a simple presumptive diagnostic test for the disease.

Virus neutralization tests were performed by mixing 20 per cent suspensions of infected chick embryo tissues with dilutions of human serum in normal horse serum, incubating at 20 degrees centigrade for 20 minutes, and inoculating hamsters or cotton rats intranasally. In cases of primary atypical pneumonia the titers of the serums taken early in the disease were low, and an increase in antibodies to high titers was observed during con-



TABLE 4.—*Clinical and Laboratory Data in Three Relatively Severe Cases of Primary Atypical Pneumonia*

	Fever maximum duration	Pulmonary lesion	Day of illness	White blood cell count	Sputum (cotton rat)	Serological titers		
						Cold agglutination	Streptococcal agglutination	Neutralization
Bu	104.8 24 days	RLL	4	7,500	2/7	10	0	< 2
		RUL	12-15	37,600	1/2	80	—	< 16
		LLL	25-30	9,200	—	160	0	< 16
		LUL	46	—	—	20	—	< 4
Yo	104. 9 days	RUL	4-8	7,650	7/12	8	—	< 2
		RLL	16	7,800	—	1024	—	> 16
			26	—	—	320	40	64
			80	—	—	160	20	64
Do	101.8 16 days	LLL	5	10,000	—	10	0	< 4
		RLL	11	7,900	—	40	10	8
			16	—	—	160	20	8
			25	—	—	160	—	16

TABLE 5.—*Results of Neutralization Tests with the Virus of Atypical Pneumonia*

	Antibody increase by virus neutralization		
	fourfold or over	twofold	none
Atypical pneumonia	12	4	1
Streptococcal agglutination positive			
Atypical pneumonia	19	6	8
Streptococcal agglutination negative			
Total atypical pneumonia (50)	31 (62%)	10 (20%)	9 (18%)
Other pneumonias (14)	0	1 (7%)	13 (93%)
Bacterial and Influenzal			

TABLE 6.—*Laboratory Differentiation of Primary Atypical Pneumonia from Virus Pneumonias of Psittacosis Group*

Case No.	Virus isolated sputum	Serum days after onset	Complement fixation psittacosis group	Neutralization virus of atypical pneumonia	Streptococcal agglutination	Cold agglutination
1	Atypical pneumonia	4	0	< 2	0	0
		25	0	< 16	0	160
2	Atypical pneumonia	4	—	< 2	—	0
		25	4	64	40	640
3	—	5	0	< 2	0	10
		17	0	8	80	80
4	—	6	0	0	0	0
		30	32	0	0	0
5	Psittacosis group	1	0	4	—	—
		30	32	4	0	—
6	Psittacosis group	Pre-21	32	0	0	—

valescence. The antibodies had decreased or disappeared at periods of several months to two years after the illness. The neutralization was found to be specific in that no increase in antibodies was observed when serums from persons with atypical pneumonia were tested against influenza or rodent pneumonia viruses, and serums from human cases of psittacosis, influenza, or bacterial pneumonia showed no significant increase in antibodies against the atypical pneumonia virus. The occurrence of these neutralization reactions is good evidence for an etiologic connection between the virus isolated in the laboratory and primary atypical pneumonia in man.

Three cases of greater severity are shown in Table 4. Serums from certain cases of atypical pneumonia develop agglutinins for an indifferent streptococcus isolated by Thomas and his associates at the Rockefeller Institute Hospital<sup>6</sup> from a fatal case. The relation of this organism to the disease is at present uncertain, but the observations that the lungs in certain fatal cases are bacteriologically sterile<sup>2,10</sup> and that atypical pneumonia may be produced in man with bacteria-free filtrates of throat washings or sputum<sup>11</sup> seem to exclude the streptococcus as the primary cause. This organism might in some cases produce secondary infection and a more severe illness.

The results of neutralization and streptococcal agglu-

tion tests on 50 patients with a clinical diagnosis of primary atypical pneumonia are summarized in Table 5. Thirty-one, or 62 per cent, of the patients had definite increases in virus-neutralizing antibodies for the new virus of atypical pneumonia; and of these, 12 also showed positive agglutination of the indifferent streptococcus. If the streptococcus were the primary cause of atypical pneumonia we should expect to find streptococcal agglutination without virus neutralization in these cases. Of the 9 patients who had no increase in neutralizing antibodies, only one had streptococcal agglutinins. In 14 patients with bacterial or type A influenzal pneumonia no significant change in neutralization titer was found.

In another series of 87 patients, cold agglutinins were found in about 70 per cent, and among those with cold agglutinins the streptococcal agglutination was positive in 60 per cent. Only 3 patients had streptococcal agglutinins in the absence of cold agglutinins.<sup>12</sup> This suggests that streptococcal agglutinins and cold agglutinins tend to occur in parallel. The serological reactions with the indifferent streptococcus are somewhat analogous to the Weil-Felix reaction with certain strains of proteus bacilli in rickettsial diseases.

#### DIFFERENTIATION OF PSITTACOSIS FROM PRIMARY ATYPICAL PNEUMONIA

The differentiation of virus pneumonia of the psittac-

osis group from the severe form of primary atypical pneumonia is important on clinical and epidemiological grounds, and this can be done by laboratory tests as illustrated in Table 6. In the first three cases the causative agent was the virus of atypical pneumonia and this was isolated from the sputum of two patients. These patients showed no significant complement-fixation titer with the psittacosis-group antigen, but neutralizing antibodies for the virus of atypical pneumonia, cold agglutinins, and streptococcal agglutinins appeared in the sera during convalescence. In the three other cases a virus of the psittacosis group was the causative agent as judged from the presence of this virus in the sputum and the appearance of complement-fixing antibodies in the serum. No significant titers of neutralizing antibodies for the virus of atypical pneumonia, no cold agglutinins, or no streptococcal agglutinins were found in these patients.

Because of the widespread infection of pigeons with the psittacosis group of viruses, outbreaks of atypical pneumonia have often been diagnosed as ornithosis or psittacosis on rather unsound evidence. In one outbreak which came to our attention<sup>15</sup> a flock of pigeons was associated with many of the cases and the virus of ornithosis was demonstrated in the birds. The human contacts, however, gave no significant serological reactions for the psittacosis group, and most of them had definite increases in neutralizing antibodies for the unrelated virus of atypical pneumonia. Although the epidemiological evidence tended to incriminate the pigeons, the laboratory findings indicated that the causative agent in these cases was entirely distinct from the psittacosis group. It would seem, therefore, as regards patients with virus pneumonia who have been in contact with infected pigeons or other birds a diagnosis of ornithosis or psittacosis cannot be made with certainty unless the same strain of virus is isolated not only from the birds, but also from the sputum of the patient, or definite increases in psittacosis complement-fixing antibodies associated with the illness are demonstrated.

#### CHEMOTHERAPY

In the treatment of virus pneumonia, sulfa drugs have generally proved to be of little value. Possible exceptions are the secondary bacterial pneumonias following influenza A or B. Penicillin has been shown to have a definite inhibitory effect on viruses of the psittacosis group in experimental animals.<sup>13,14</sup> Although no clinical evidence of its effectiveness on psittacosis in man is yet available, a trial of this drug in severe cases which presumably belong to the psittacosis group would appear justified. There is no evidence at present that penicillin is effective in the more prevalent and milder primary atypical pneumonia not caused by psittacosis-like viruses.

#### DISCUSSION

The present evidence suggests that the majority of cases of virus pneumonia are caused by a single agent which in recent experiments has been transmitted to chick embryos, cotton rats, and hamsters. The relation of this virus to sporadic cases of undifferentiated respiratory disease without pneumonia and to epidemics of influenza-like illness not caused by the influenza virus is under investigation. It is hoped that the recent advances in knowledge of the etiology of primary atypical pneumonia and other virus pneumonias may lead to a better understanding of the epidemiology of these diseases and to the development of methods of control, immunization, or chemotherapy.

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## CURRENT CONCEPTS IN VARICOSE VEIN THERAPY

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ANY clear evaluation of the methods now being employed in the treatment of varicose veins is contingent upon a knowledge of both the normal and abnormal anatomy and physiology of the peripheral venous system. Several methods of therapy regarded as definitive by their proponents fall short of their goal because basic factors are either ignored or not fully appreciated.

If an adequate solution to the problem was available, one approach would be universally recognized and no further investigative procedures would be indicated. Conversely, if the problem remained unsolved and no interest was being manifested, little would be found in the literature. That progress is being made towards an effective approach is readily borne out by the many therapeutic proposals currently being advocated in medical journals. This makes for a healthy situation which, if continued, will assuredly result in an effective means of combating a common and distressing malady.

#### ANATOMY

Variations in the course taken by the veins of the lower extremity are numerous, however the normal anatomic arrangement is such as to allow an unimpaired return blood flow. For practical purposes this venous system can be divided into four component parts, of which only the features pertinent to peripheral venous pathology will be discussed. To be technically correct, any description of venous anatomy should begin at its peripheral source and be carried cephalad. However, for reasons of surgical convenience a reverse order is utilized here, unless otherwise specified.

I.—*The deep system*, namely the femoral vein and its tributaries. Adequate descriptions of this phase of the venous return are readily available in the literature.

II.—*The superficial system*, which is composed of the internal saphenous vein emptying into the femoral vein, and the external saphenous vein which empties into the popliteal vein. While no specific pattern prevails for these two superficial vessels, a more or less general picture has evolved from various studies. The juncture of the internal saphenous vein with the femoral vein is a constant finding. The three main tributaries in the sapheno-femoral region, namely the superficial circumflex iliac, the external pudendal, the superficial epigastric veins are usually present although variation and duplication are not uncommon. Tributaries of variable size arising from the anterior, mesial and posterior aspect of the thigh



join the internal saphenous along its course. In addition, any number of anomalous tributaries may be present. Quite recently it has been conclusively demonstrated that the saphenous stem, or one of the stems if two are present, dips under the superficial layer of the deep fascia in the mid-thigh, where it remains throughout its course down the thigh and leg, although tributaries from it may emerge through the fascial layer to lie superficial to the deep fascia. The importance of this subfascial stem becomes apparent when it is realized that any vein communicating between it and the deep system could, in the face of inadequate therapy, conceivably perpetuate any pathology existing in the superficial venous system. (Figure 1). The external saphenous vein has its juncture with the popliteal vein in the upper portion of the popliteal space. It originates on the dorsolateral aspect of the foot, courses posterior to the external malleolus up the posterior lateral aspect of the leg, piercing the deep fascia in its mid-third, from whence it continues upward to join the popliteal vein. The femoro-popliteal vein draining the posterior aspect of the thigh communicates with the external saphenous in the popliteal space.

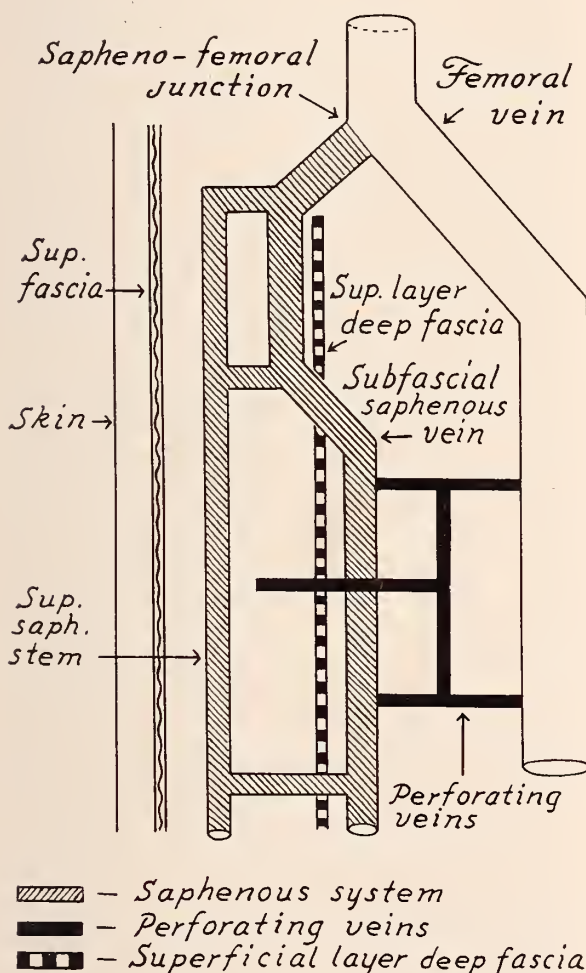


Fig. 1.—Schematic drawing showing the relationship of the internal saphenous and perforating veins to the superficial layer of the deep fascia.

III.—Veins, both superficial and deep, emptying into the internal iliac vein. Perhaps further anatomic studies will reveal these veins as contributing factors in both the recurrence and perpetuation of varices, either directly, or by serving as communicating channels for the

retrograde flow of blood from the internal to external saphenous vein.

IV.—Communicating veins connecting the superficial and deep systems. Although inconstant in number these short venous channels are invariably present and normally permit the flow of blood from the superficial to deep system, valves preventing a reverse flow. Anatomical studies of the leg by Linton<sup>1</sup> and more recently of the thigh by Sherman<sup>2</sup> have corroborated this finding and also have quite conclusively demonstrated that in the face of dilatation and resultant valvular incompetency these perforating veins may serve as either actual or potential sources for retrograde blood flow. In attempting to reduce the incidence of recurrences, the clinical significance of these offending perforating veins cannot be minimized.

#### PHYSIOLOGY

The return of blood from the lower extremity is contingent upon three complementary factors, namely, capillary blood pressure; venous support by muscle and fascia in conjunction with competent valves; and changes in intrathoracic pressure associated with diaphragmatic movement. The force of gravity, mechanical impingement and increased intra-abdominal pressure are among the important factors which militate against a return flow.

Normal capillary blood pressure is quite unable to neutralize this constant venous back pressure, so the progression of venous blood is largely dependent upon pressure applied by contiguous musculature and fascia. In the normal vein with competent valves, external pressure results in the displacement of venous blood towards the heart. This action results in the segmental reduction of venous pressure, and since no retrograde flow of blood follows the release of pressure because of a competent valvular mechanism, the evacuated segment can only fill from below. These coördinated factors are the salient features in venous return from the lower extremity in normal individuals.

In contradistinction to the deep system which has both the protection and support of the contiguous musculature and fascia, the superficial venous system has but little fascial and no direct muscle support. As a consequence, the venous return must largely depend upon pressure exerted by indirect muscle action plus the resiliency of overlying superficial structures. The latter quality obviously decreases as the subject becomes older and as a result, vessel wall distention can be unimpeded at a time when support is most essential. Concomitant with this process valvular incompetency develops, and in the face of this incompetency any beneficial action derived from adjacent support is immediately lost, as external pressure displaces blood not only towards the heart, but distally as well. Release of external pressure also allows filling from both above and below, with the result that no venous return is effected. Once the process is set in motion it is doomed to pathological progression as the venous back pressure increases and produces even more involvement. Valvular incompetency soon embraces the communicating veins, and as a result, blood spills from the deep into the superficial system in a not inconsiderable amount, and a further increase in peripheral venous pressure is the inevitable sequel. This in turn is followed by an increased capillary blood pressure which seriously impairs normal capillary function. Fluid balance between capillary and tissue space is disturbed so that fluid with an abnormally high protein content accumulates in the tissues. This favors fibroblastic proliferation which can easily set the stage for eventual scarring and ulcer formation. In other words, a superficial system which normally aided in the return of blood to the general circulation is not only no

longer able to do so, but actually contributes to a highly impaired nutritional state.

#### THERAPY

Any effective approach must do one of two things; reestablish the normal physiologic function, or eliminate that phase which has become a liability to the system. The first is not feasible because the venous damage is irreparable either through rest, medical or surgical intervention. The only other alternative is the removal of the pathology which is hazardous to the individual.

Presumably working from a valid premise that an attempt should always be made to effect relief with a minimum of intervention, initial attempts were made to secure benefit by injecting thrombogenic, and later, sclerogenic substances into the diseased vessels. In other words, a treatment which usually is not too painful and allows the patient to be ambulatory with a minimum of disability would seem to offer much. However, subsequent events have shown that following injection therapy the endothelium is rarely completely destroyed, and the residual islands of undamaged intima serve as bases from which regeneration usually proceeds. Organization and recanalization of the thrombosed segments are almost inevitable sequelae, thus reestablishing the preëxisting pathology. The incidence of recurrence following sclerotherapy in no sense militates against its use in certain situations where it is not only indicated but highly preferable, namely in patients with limited life expectancy and in those suffering from constitutional disease which would make surgery unduly hazardous. Injection therapy might also be condoned in the treatment of minor varices, but it should be borne in mind that palliative sclerosive therapy will not only have little effect on the progress of the disease, but may also expedite its progression through destruction of remaining competent valves.

Perhaps the currently most popular surgical procedure in the treatment of varicose veins is ligation of the internal saphenous vein at its juncture with the femoral vein. Unless this operation is done carefully with a full appreciation of the regional anatomy, much of the benefit which might conceivably accrue is lost. The division of the saphenous must be done right at the femoral vein, and all tributaries must also be divided to avoid reestablishment of a retrograde circulation through collaterals. The femoral vein must be identified and exposed for some distance, both proximal and distal to the saphenous junction, to avoid leaving any tributaries, some of which could easily be confused with the femoral vein. The latter situation is perhaps more frequent than commonly supposed.

While division of the saphenous vein at its juncture with the femoral is within itself a very valuable procedure in the treatment of varicose veins, its inadequacy becomes manifest when the high incidence of clinical recurrences is noted. Some of the highly spectacular results being reported in the literature following this procedure can possibly be attributed to one or both of the following conclusions: complete disregard of post-therapy varicosities because the patient is asymptomatic; or attributing residual varicosities to a process quite independent of that associated with surgery. Either premise is untenable in any proper compilation of results.

That the communicating veins are etiologically important in recurrences and perpetuation of varicose veins is becoming increasingly apparent. Attempts have been made to combat this in various ways, such as multiple ligations of the saphenous stem or its tributaries at various levels which are presumed to coincide with their points of juncture with perforating veins. These approaches have not, on the whole, proved effective because collateral

pathways soon circumvent the obstruction thus created, or recanalization takes place directly at the point of ligation. It is not illogical to deduce that any surgical approach which fails to permanently eliminate this source of retrograde blood flow will perforce offer a lower incidence of effective relief.

The use of sclerosing solutions at the time of surgery or postoperatively to combat residual varicosities is also a common procedure. Abundant evidence has accumulated to substantiate the statement that recanalization almost always follows sclerosing therapy, particularly in the face of a maintained venous back pressure, therefore using this agent as a complementary procedure should do little to enhance the permanency of the treatment.

#### SURGICAL PROCEDURE

Since a damaged saphenous vein cannot be corrected and interruptions in its course will be reestablished through collateral pathways and recanalization, the remaining alternative is removal of the saphenous vein from its juncture with the femoral vein down to a point below the lowest leg perforator. Appropriate treatment should also be afforded all demonstrable incompetent thigh and leg perforating veins. The following surgical procedure, not unlike that advocated by Sherman,<sup>2</sup> is herewith suggested. Preoperative sclerosing of varicosities below the knee expedites subsequent surgery and also limits postoperative bleeding. Sclerosing solutions are used here and later as a surgical adjunct rather than as a definitive therapeutic agent.

Under spinal anesthesia, an incision is made below the inguinal crease and the saphenous stem is exposed and divided. Sufficient sclerosing solution is then injected into the distal stem to insure the formation of a thrombus, or if two stems are present, identical treatment is given both. The sapheno-femoral junction is then dissected in the usual manner, isolating each tributary as far from its point of junction with the saphenous or femoral vein as is feasible, where it is ligated and divided. As previously stated, great care must be taken to completely expose the sapheno-femoral junction so that no tributaries may be left as a potential source for reestablishment of collateral circulation and recurrence of the venous pathology. The saphenous vein is then ligated flush with the femoral vein and transfixed. The distal stem is then freed, usually digitally, to a point which approximates the juncture between the proximal and middle thirds of the thigh on its medial aspect, where an incision is made. Any tributary found on this portion of the saphenous stem may either be divided through the initial incision or brought down through the mid-thigh incision and divided. In the mid-thigh it is invariably necessary to incise the superficial layer of the deep fascia to expose the inner saphenous stem. In the presence of a double stem, one stem will fail to dip beneath the fascia, remaining superficial throughout its entire course. This accessory stem is followed as far distally as practicable, using the same technique described for the main saphenous vein. The medial surface of the main or inner saphenous stem in this region will reveal a perforating vein which through careful dissection, can be followed to its approximate junction with the femoral vein, where it is ligated and divided. This is necessary in order to insure the elimination of direct as well as indirect accessory communicating veins. Perforating veins of this type are probably responsible for some of the recurrences noted in less extensive operative procedures. At this point, the fascia over the sapheno-femoral junction is closed with a purse string suture of black silk and the inguinal incision is closed with interrupted mattress dermal.

The stem is then followed distally with a Mayo stripper to a point immediately above the knee where



additional perforating veins may be present as indicated by tests done previous to surgery. However, geniculate tributaries are an almost constant finding in this area, as well as below the knee. Because it creates a bifurcation, any sizable tributary will offer resistance to the Mayo stripper and this in turn will serve as a guide as to where additional small linear incisions should be made. At each point of bifurcation, the offending tributary may either be ligated or divided, or if its size warrants, it too may be followed distally either through digital dissection or use of the stripper.

Essentially the same basic pattern may be followed in the leg where previous tests serve as a guide to possible points where perforating veins may be present. Small exploratory incisions may also be made in these areas, and the offending vessels traced to their point of entry into the deep fascia, where they are tied and divided; the remaining fascial aperture is then closed with appropriate sutures. Not infrequently the site of a tributary will coincide with, or approximate the level of a perforating vein. As a consequence, the total number of incisions should at no time be excessive. At any rate, the saphenous dissection is carried to a point below the lowest perforating vein, where it is divided. All wounds are closed with interrupted mattress dermal.

Whenever the short saphenous is obviously dilated or incompetent as revealed by appropriate tests, the patient is turned and a transverse incision is made on the lateral aspect of the popliteal fossa. The fascial sheath is incised sufficiently to give adequate exposure of the underlying structures, the short saphenous vein is identified and ligated at its point of juncture with the popliteal vein. Care should be exercised not to injure the tibial nerve which lies immediately lateral to the popliteal vein. If indicated, the short saphenous is then followed distally in the same manner described for the internal saphenous; any perforating veins encountered, particularly in the mid-calf region, should be followed to their approximate point of juncture with the deep system. The fascial incision in the popliteal fossa is then closed with interrupted black silk. The skin closure is made as previously described. To allay any subsequent bleeding, firm pressure bandages are then applied from the toes to the groin.

The procedure advocated requires meticulous and painstaking surgery and the operation is not a short one, but when carefully done there is no attendant shock and the mortality is infinitely lower than any other surgical procedure of comparable duration. Regardless of the extensiveness of the surgical procedure, early ambulation is a mandatory order, and only under extenuating circumstances is the patient allowed to remain in bed longer than twenty-four hours after surgery. Should the latter be necessary, active and passive leg exercises are instituted to combat venous stagnation. Patients usually leave the hospital the first postoperative day with a minimum of discomfort. Any postoperative edema, attributable to circulatory and lymphatic readjustment, is transient, and can be readily controlled with firm elastic bandages.

Attempts at complete removal of the saphenous vein were made many years ago. However, the reasons the procedure initially fell into disrepute have been currently largely eliminated. When it was originally introduced, no preoperative sclerosing was done to limit surgical bleeding and obviate postoperative hemorrhage, and the dissection of the sapheno-femoral junction was undoubtedly not complete in many instances. Then too, the importance of the perforating veins was not appreciated and these were merely torn in removal of the saphenous stem, thus leaving intact, particularly in cases where the inner saphenous stem was undisturbed, direct as well as indirect connections between the deep and superficial systems. An unnecessarily high percentage of recurrence

naturally resulted. In addition, patients were kept in bed following surgery for lengthy periods, a fact which materially contributed to postoperative complications. All these factors played an important part in discrediting what was really a material advance in varicose vein therapy.

#### CONCLUSION

The surgical treatment outlined is more extensive than its predecessors, but any more conservative approach at least fails to eliminate all currently demonstrable etiologic factors. Regardless of the type of therapy, under no circumstances can the incidence of residual or recurrent pathology be considered negligible, and surgical results are still influenced by the extent of the varicosities at the time of surgery. Manifestly a much better result can be anticipated when the pathology is limited in both extent and severity. At any rate, those who devote themselves to the problem will find venous pathology of the lower extremities a most interesting field in which much constructive work is yet to be done.

The above procedure is suggested as a means of obtaining a more satisfactory end result in the treatment of varicose veins.

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## RHEUMATIC FEVER: ITS RECOGNITION\*

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*I.—Introductory Statement.*—The importance of the topic to be discussed is evidenced by the facts that 2 per cent of the school children of the United States have heart disease as a result of the rheumatic state; that 98 per cent of all heart disease in patients under 20 years of age is of rheumatic fever etiology; that it causes more deaths in the first two decades of life than all of the communicable diseases plus pneumonia; that it causes annually ten times more deaths than infantile paralysis; and that a study of the young men rejected for military service because of heart disease showed the rheumatic state to be the etiologic factor in 51 per cent in Boston, 70.3 per cent in Chicago, 64.4 per cent in New York, 65.9 per cent in Philadelphia, and 39.6 per cent in San Francisco. (White, Levy & Stroud; J.A.M.A., Dec., 1943.) The importance is further emphasized by the recent knowledge that rheumatic fever is not a disease confined to the temperate zone but that it is almost as prevalent in subtropical climates as in the temperate climates (Sampson; *Amer. Heart*, Feb., 1945) and that even the acute fulminating type of the disease is frequently seen in the tropics. (Huntington; *Personal Communication*, 1945.) The belief that the disease is confined to the temperate zone is due to the more frequent occurrence of the severe types in that zone.

This important disease now becomes a global problem. Hereditary susceptibility to the disease, previously thought to be a Mendelian recessive character (Armstrong and Wheatley; *Metropolitan Life Insurance Co.*, Nov., 1944)

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may be largely due to poor nutrition or to group crowding as shown by the experience of the Army and Navy in training centers. Good nutrition and segregation may be a large factor in protecting the individual from an inciting agent such as the Beta streptococcus hemolyticus (Wilson; Rheumatic Fever, Commonwealth Fund, 1940). It is true that children of parents who have had rheumatic fever are more susceptible to the development of the disease, in the presence of a streptococcus hemolyticus infection, i.e., tonsillitis, scarlet fever and otitis media, than are those children of non-rheumatic parents. (Paul; Epidemiology of Rheumatic Fever, 1943.)

#### DEFINITION

Out of the combined experience of the clinician, pathologist, bacteriologist, allergist, neuropsychiatrist and dermatologist working with this disease in a very large group of patients of military age, a consensus of opinion has gradually developed that we are dealing with a disease entity best characterized by the following definition: *Rheumatic Fever is a systemic anaphylactic inflammatory disease with protean manifestations of varying severity and duration.* Pathologic, histologic and clinical observation shows that the disease is a hypersensitivity angitis manifest in all of the body structures from the skin to the smallest subdivision of the viscera.

#### THE PHASES OF THE RHEUMATIC STATE

The *first phase* of the disease is that period of illness during which the patient is the host to the beta type of the hemolytic streptococcus. From military experience it has been learned that about 5 per cent of trainees develop some manifestation of a hemolytic streptococcus upper respiratory infection. This upper respiratory infection may take the form of a pharyngitis, tonsillitis, otitis media or a sore throat with a scarlatiniform rash, the so-called scarlet fever. Approximately 5 per cent of this group of patients develop the symptoms and signs of rheumatic fever. Therefore, it is logical to consider every patient with a hemolytic streptococcus throat infection a potential rheumatic fever subject. In those susceptible individuals who develop rheumatic fever it is proper to consider this the first phase of the disease.

The *second phase* is the period of latency lasting from one to four weeks in duration. It is during this, the second phase of the disease, that the patient develops a hypersensitivity, is found to tire easily, may run a mild fever and have a persistent leucocytosis, elevated blood sedimentation rate and a gradual increase in the level of the antistreptolysin titre. (Rautz; Paper read before the California Heart Association, 1944.) This second phase is frequently noted only as an interval of time wherein the painstaking physician will find that the patient is not symptom free.

The *third phase* is the well-known period of rheumatic fever activity. The protean manifestations may be grouped into four distinct types, each of which with its symptom complex will be described in detail subsequently. The severity and duration of the phase of activity cannot be predicted as the most fulminating onset may be followed by a relatively short period of activity, for example, from four to six months, while in the sub-clinical type activity may persist for years.

The *fourth phase* is the period of rheumatic fever inactivity. It is the period of the arrested rheumatic state, or the period of rheumatic quiescence. This phase of the disease may be long or short, depending upon reactivation of the rheumatic state. The mild pain occasioned by muscle jelling, joint stiffness and soreness resulting from fatigue or exposure do not constitute a reactivation of the rheumatic process. An upper respiratory infection followed after a short interval of fever, tachycardia,

malaise, dyspnea, migrating polyarthritis with concomitant laboratory findings of an increased blood sedimentation rate, leucocytosis and electrocardiographic changes constitute a reactivation. Of a large number of patients returned to a rheumatic fever unit for supposed reactivation, only 2.4 per cent were found to have a reactivation. Thus, the fourth phase of the disease begins with the termination of rheumatic fever activity and ends only if reactivation occurs.

#### ONSET OF THE RHEUMATIC STATE

The beginning of the active stage of rheumatic fever may be insidious and go unnoticed and undiagnosed for a long period of time, as shown by the survey of re-jeetees with cardiovascular disease. (Levy, Stroud and White; J.A.M.A., Dec., 1943). It was found that 71.2 per cent of patients in four cities and 50 per cent in two cities did not give a history of the acute rheumatic fever. On the other hand, the onset of the rheumatic state may be very severe. The younger the patient, the more severe the onset, appears to be the rule. The latency phase of the disease is ended by an acute illness characterized by migrating polyarthritis, fever, shortness of breath, tachycardia out of proportion to the elevated temperature, loss of appetite and severe sweats. The patient is restless but moves the extremities very little because of painful joints. The face is flushed. The tongue and lips are dry. The skin is hot and dry alternating with periods of drenching sweat. The migrating polyarthritis usually begins in the larger joints such as the knees, ankles, elbows, wrists and at times the hip and shoulder joints. The periarticular tissues are swollen, hot and tender. As the process begins to subside in one joint, it lights upon an analogous joint. The polyarthritis persists a relatively short time after the patient has been put to rest. The administration of salicylates sufficient to raise the blood level to 30 milligrams per 100 cc. of blood relieves the polyarthritis promptly. Those patients with sedentary duties do not develop the severe joint manifestations that characterizes the physically active group.

The fever may be absent, moderate or severe. The severely elevated temperature persists for 10 to 18 days and then gradually subsides or it may persist at a low level for months.

The shortness of breath is usually overlooked. It is very common in the acute stage and is the first sign of myocardial failure and/or rheumatic pneumonitis.

The tachycardia is out of proportion to the degree of fever. Even though fever is absent, a tachycardia is usually present. The tachycardia persists as long as there is activity of the disease.

During the acute onset, carditis is shown by dilation, gallop rhythm and electrocardiographic changes may present itself. Pericarditis as indicated by a to-and-fro friction rub or by an effusion, is not frequently diagnosed. In our series of patients it was diagnosed clinically in 2.82 per cent of cases. Endocarditis is diagnosed only if the murmur is: (1) diastolic in time; (2) if a systolic murmur persists through six months' observation; (3) if the systolic murmur remains the same or grows worse in intensity and is heard in all positions and in all phases of respiration; (4) if the systolic murmur is transmitted; and (5) if the chamber enlargement or systolic thrill are found in the later period of the six months' observation. These signs of carditis may be present early in the acute onset but most frequently are later manifestations.

Pneumonitis was the presenting factor in 12 per cent of two hundred patients with prolonged rheumatic fever. The symptoms of rheumatic pneumonitis in order of their frequency appear to be, shortness of breath, tachycardia, fever, pleuritic pain, malaise, and cough. The shortness of breath and tachycardia may precede the fever, pleurisy,



and cough by many hours to a few days. The physical findings are those of small areas of dullness and diminished breath sounds anywhere in the lung fields. Fine râles soon appear. The patchy areas of pneumonitis shift from one site to another. The upper lobes are involved as frequently as the lower lobes. A pleural effusion may appear very rapidly. It disappears with equal rapidity unless congestive failure intervenes. Thorocentesis, like pericardial drainage, is seldom necessary. The x-ray findings of rheumatic pneumonitis are those of so-called primary atypical pneumonia. The pathologic histology is that of a pulmonary angitis with multiple small infarctions.

Weight loss and loss of appetite are very common at the onset. Returning appetite and gain in weight are good indices that the rheumatic activity is subsiding.

Abdominal pain is due to localized peritoneal irritation resulting from the angitis or capillary involvement in the parietal and visceral peritoneum. Confusion with acute appendicitis is not frequent. In the acute onset of rheumatic fever, abdominal pain is frequently due to diaphragmatic pleurisy or to peritoneal irritation. Usually the dyspnea, tachycardia, signs of pneumonitis or carditis, and polyarthritides are out of proportion to the abdominal pain. If the abdominal pain localizes and the classic picture of acute appendicitis persists, then operation should be done. In our series as will be reported in another paper, the diagnosis was not difficult. The problem of acute appendicitis at the onset of acute rheumatic fever was not frequently encountered. The patients who developed acute appendicitis did so during the prolonged convalescence and the number did not exceed the expectancy in a similar age group of non-rheumatic fever patients.

Chorea at the onset of acute rheumatic fever is very rare in our patients. Only .04 per cent of rheumatic fever patients developed chorea at any time during the period of observation.

At the onset of the disease, erythemas are frequent. The erythemas are those of an anaphylactic nature, varying from erythema marginatum to urticaria. Erythema multiforme and erythema nodosum are not manifestations of rheumatic fever activity.

Subcutaneous nodules are not frequently seen at the onset in patients of military age. Subcutaneous nodules when present, do not necessarily indicate a severe rheumatic activity.

Epistaxis is quite common at the onset of the disease in children. In the age group from 18 to 25 years 0.3 per cent patients show this phenomenon. However, in another study (Montgomery, 1945) it has been shown that there is a very definite increase in capillary permeability and fragility in the rheumatic state.

Concomitant with the onset of the disease there is an increase in the leucocyte count and an elevation of the blood sedimentation rate and of the antistreptolysin titre. None of these findings are specific for the rheumatic state.

#### THE CLINICAL TYPES OF RHEUMATIC FEVER

There are four clinical types of rheumatic fever recognizable, namely, the acute fulminating, the subacute polycyclic, the subacute monocyclic and the subclinical.

*The Acute Fulminating Type* was found to occur at a rate of 4.3 per cent in a series of patients who gave evidence of rheumatic activity for more than six months. This type is more frequent in childhood. The acute fulminating type is characterized by a sudden onset with migrating polyarthritides, fever, restlessness, severe tachycardia, dyspnea and drenching sweats. Carditis appears rapidly as shown by dilatation, gallop rhythm, murmurs, and at times pericarditis. Pneumonitis is present in many patients. Pneumonitis can be detected by careful physical examination, but is more frequently diagnosed by the

x-ray studies of the lungs. The migrating polyarthritides is of short duration although usually severe at the onset. The fever is relatively high, ranging from 101 to 103 degrees. The acute febrile period lasts from 10 to 18 days and then subsides with a rapid convalescence or goes into a prolonged low-grade state of activity. The tachycardia is marked and is the last sign to disappear. The leucocyte count is moderately elevated with a marked increase in the granulocytes. The urine may contain albumen and a moderate number of cells. Approximately 20 per cent of patients in this group show electrocardiographic changes indicative of myocardial and pericardial involvement. The acute fulminating type usually terminates with one cycle. This group represents those patients who are most susceptible to the disease. Although the mortality is low in the primary attack, due to a marked hypersusceptibility, these patients are more likely to have fatal reactivations.

*The Subacute Polycyclic Type* is similar to the acute fulminating during the onset except that it is less severe. It is more frequent. The percentage of occurrence in our series of patients was 27.6 per cent. The cycles may be short and spaced at long intervals, or in the more severe subtypes the cycles may be long and spaced at shorter intervals of time. It is in this type that the mortality is the greatest. Concerning fatalities 63.6 per cent in our series of patients were in this group. Likewise in this group with repeated cycles of activity, the most marked cardiac enlargement, most frequent signs of endocarditis and pericarditis are found. During one or all of the cycles pneumonitis of greater or less degree occurs. After the first cycle, polyarthritides is usually absent, and the response to salicylate therapy is poor. Congestive heart failure, complicating carditis occurs almost exclusively in this group of cases.

*The Subacute Monocyclic Group* is the most frequent of the four types occurring in our series in 61.3 per cent. The onset may be very mild and scarcely recognizable, or it may be moderately severe with moderate fever, mild migrating pains, a definite tachycardia and moderate elevation of the leucocyte count and blood sedimentation rate. The response to salicylates is usually prompt and the acute onset lasts for seven to fifteen days. Thereafter the course may be that of a rapid return to the stage of quiescence so that full activity may be resumed in from four to six months; or the course may be long with signs of mild activity persisting over a period of six to nine or more months.

*The Subclinical Type* was found in 5 per cent of our series. This group comprised those patients who may or may not have had an upper respiratory infection, and who in the course of a check up examination were found to have developed definite signs of rheumatic heart disease. Such signs are those of cardiac chamber enlargement, mitral and/or aortic insufficiency murmurs, paroxysmal tachycardias and auricular fibrillation. Upon careful observation this group of patients exhibited a few signs of rheumatic activity such as a cyclic low grade temperature, and a mildly increased sedimentation rate. At other times no confirmatory evidence of rheumatic activity was found. Two patients within this group died suddenly. Death in each instance was due to an acute anaphylactic reaction with the pouring out of collagen into the walls of the coronary arteries sufficient to cause an occlusion and myocardial infarction.

#### THE CRITERIA FOR THE DIAGNOSIS OF RHEUMATIC FEVER

The diagnostic criteria have been previously laid down by Swift, H. E. (J.A.M.A., June, 1929), and by Jones, D. E., (Stroud; Cardiovascular Disease, 1943).

The diagnostic criteria are subdivided into major and minor groups:

The *major criteria* are five in number, namely, a history of a previous attack, carditis, fever, migrating acute arthritis and chorea;

The *minor criteria* in order of their relative importance are, pneumonitis, tachycardia, subcutaneous nodules, erythemas, epistaxis and purpura, weight loss and abdominal pain. Iritis and conjunctivitis are too infrequent and indefinite to be included.

A previous history of rheumatic fever was obtained in 28.1 per cent of our patients. The importance of a previous history is of great value. Too often, however, mild arthralgia and muscle jelling are mistaken for a previous history. A previous history is of great diagnostic helpfulness when a patient presents himself with one or more of the major criteria and two or more of the minor criteria.

#### MAJOR DIAGNOSTIC CRITERIA

Carditis is probably the most important of the major diagnostic criteria. Carditis can be said to be present when a tachycardia, especially a resting pulse of 100 or more, persists; when there is dilatation of the heart as shown by enlargement and/or gallop rhythm; when pericarditis is evidenced by a to-and-fro pericardial friction rub and/or a pericardial effusion; when myocarditis is demonstrated by dilatation, gallop rhythm and electrocardiographic changes; and when endocarditis is established by hearing definite organic cardiac murmurs.

Fever is considered to be the most frequent evidence of an active rheumatic state. It is the most reliable evidence of activity in the absence of demonstrable carditis. At the onset the temperature range may be normal or as in the more severe types as high as 102 to 104 degrees. The degree of fever is not the paramount observation, but persistence of the fever is of utmost importance. No clinician can be sure that activity has ceased unless a carefully taken and recorded temperature curve has been observed for at least six to eight weeks time. Persistent fever in the subacute types of the disease takes one of two forms. The more frequent form is an evening rise to 99 to 100 degrees. The more insidious and most frequently unobserved form is a cyclic type of curve. In this form the temperature remains at a normal or a slightly subnormal level for one to two weeks and then becomes mildly elevated for a few days or as long as a week. It is rare for fever to be the only evidence of activity. Persistent fever must be viewed seriously especially if two or more minor criteria are present.

Polyarthritis, by which term is meant migrating acute arthritis, for over three centuries has been considered the significant sign of the disease. In recent years the literature has emphasized the unimportance of the joint signs. In the primary attack the joint signs are usually prominent and frequently the presenting symptom and sign. The major joints become red, hot, and swollen in a migrating fashion. With rest, the joint signs disappear quickly. The salicylates in adequate dosage are specific and prompt in action. The red, hot swollen joints subside leaving no residual pathology in the joints of the younger age groups. In those patients in the third decade of life arthralgia may persist. The persistent arthralgia is not considered a sign of activity, when all other criteria have disappeared. If one major or two minor criteria persist, then the complaint of painful joints must be considered evidence of activity.

Chorea is a relatively rare condition in the second and third decades of life. It has occurred in our series of patients in .047 per cent. None of the cases have exhibited the severe choreiform movements seen in childhood. There have been other neurological manifestations occurring during the active course of the disease. Two patients developed temporary hemiplegia with gradual complete recovery. Six patients developed unilateral or

bilateral brachial plexus involvement varying from weakness and pain in the entire upper extremity to wrist drop. Two patients developed temporary foot drop. These neurologic signs were not considered of psychic origin. With continued treatment of the rheumatic state the organic neurogenic signs cleared up.

#### MINOR DIAGNOSTIC CRITERIA

The minor criteria in the order of their relative importance are herewith described.

Pneumonitis has been overlooked by most American clinicians until: Baas, C. P. and Schwartz, S. P. (Am. Ht. J., April, 1927); Paul, J. R.: (Medicine, December, 1928); Swift, H. F. (J.A.M.A., June, 1929); Coblurn, A. F. "The factor of Infection in the Rheumatic State," 1931; and Eiman, John (Am. J. Med. Sc., March, 1932)—called attention to the clinical and pathologic findings. The constant occurrence of pneumonitis in the acutely ill and the frequency with which it is found in the very mild stages of activity emphasizes its importance. Frequently the chief complaint of the patient is dyspnoea and the first outstanding sign is that of pneumonitis, likewise, it is frequently the first sign found in a current cycle and in a reactivation. When the x-ray picture of the lungs is that similar to an atypical pneumonia and the sputum yields no specific organism in a rheumatic fever susceptible patient, the diagnosis of rheumatic pneumonitis is considered established.

Tachycardia is a minor diagnostic criteria which if constant and persistent during sleep is of positive value. Paroxysmal tachycardia and auricular fibrillation are rare in our series of patients.

Subcutaneous Nodules are not seen frequently. These are a definite sign of activity. In the past their significance has been considered ominous, but perhaps that is due to the fact that they are not looked for carefully in the subacute and mild cases. They are a diagnostic sign but do not carry the poor prognosis formerly attributed to them.

The Purpuras and Epistaxis. There is a definite increased fragility and permeability of the capillaries in the rheumatic subject as is shown by one of our co-workers, Leut. Comdr. Hugh Montgomery. The purpuras are seen rarely. Not over .3 per cent in our entire case load have shown purpura. Epistaxis is of similar significance and occurs very infrequently in the 2nd and 3rd decades. When purpura is present it is a very helpful diagnostic sign.

Weight Loss is a very common occurrence in the acute phases of the active state and weight gain is commensurate with the improvement in the patient.

Abdominal Pain has been considered of great importance in the literature. It is a relatively uncommon occurrence late in the disease. At the onset of an acute episode there may be abdominal pain without definite localizing signs but if there is a previous history of rheumatic fever and the findings of shortness of breath and tachycardia out of proportion to the fever, and especially if there are joint manifestations, it is safe to wait and watch, but if in doubt, then operate as the risk is small.

Recurrent Cycles may be initiated by surgery such as dental extractions or tonsillectomy. The fracture of bones is almost sure to set up a recurrent cycle of activity. Therefore it is unwise to do dental extractions or to perform tonsillectomy until six months have elapsed after activity has ceased. Fractured bones must be firmly fixed as soon after fracture as possible.

Laboratory Findings are not specific in rheumatic fever. There is no specific laboratory diagnostic test.

Anemia of the secondary type may develop rapidly in the very acute types. In the mild types of the disease anemia is uncommon.



*Leucocytosis.* The white blood count during the acute onset may be as high as 15,000 to 24,000 with as much as 90 to 95 per cent polymorphonuclear leucocytes. In the subsiding stage the leucocyte count falls rapidly to normal and is not a reliable guide as to the degree of activity.

*Anti-Streptolysin Titre* is elevated at the onset and continues to remain elevated for a long period of time. Because of the technical difficulties and because it remains elevated after other signs of activity have disappeared, it is not a satisfactory guide as to the degree of activity or guide in treatment. Its greatest value is in the epidemiology of rheumatic fever.

*Blood Sedimentation Rate* is elevated during the time of the phase of activity. It is the best single guide to the degree of activity. If the sedimentation rate remains elevated when all other signs of activity have disappeared, then the clinician must rule out other causes for an increased sedimentation rate.

*Electrocardiographic Changes* indicative of rheumatic activity are three—first a shifting A.V. conduction time, especially if the P.R. interval is well over .24 seconds. This change is frequently seen in varying degrees up to the Wenckebach phenomena and complete auriculo-ventricular disassociation; second, the typical electrocardiographic picture of pericarditis and third, the Q.R.S. and T. wave changes which are seen in myocardial damage resulting from the anoxia of coronary insufficiency. The coronary insufficiency is the direct result of arteritis of moderate to severe degree.

*Urinary Changes* in our experience have been minor and notable for their absence. In the acute phases albumin and a moderate number of cells may appear.

#### THE DIFFERENTIAL DIAGNOSIS

*Rheumatic Fever* in its acute form must be differentiated from Dengue Fever, Undulant Fever, Rheumatoid Arthritis, Chronic Osteoarthritis and Tuberculosis. This is best done by evaluating the above outlined criteria and by close observance of the clinical course.

In *Dengue Fever* the course is short, and there is no carditis or prolonged elevation of the sedimentation rate or the antistreptolysin titre.

*Undulant Fever* is ruled out by a persistently negative cross agglutination test with the *Bacillus Abortus* and *Bacillus Melletensis* and by the failure to develop carditis.

*Rheumatoid Arthritis* is difficult to differentiate early, but time and visual joint changes, and x-ray joint changes together with a low antistreptolysin titre point to this entity rather than rheumatic fever.

In *Osteoarthritis*, the development of x-ray evidence of joint pathology and the lack of most of the major and minor criteria of rheumatic fever serve to make the differentiation early.

*Tuberculosis* is confused by the prolonged fever, but here again the absence of the other four major criteria and most of the minor criteria rules out rheumatic fever.

#### SUMMARY

The recognition of rheumatic fever is discussed. The onset of the disease is described in detail. The four phases and clinical course of the disease are presented. The diagnostic criteria and differential diagnosis are formulated. Precise knowledge of the many manifestations of the disease will lead to early recognition of the rheumatic state.

U. S. Naval Hospital.

I esteem it a chief felicity of this country that it excels in women.

—Emerson, *Essays, Second Series: Manners.*

## RHEUMATIC FEVER CASE-FINDING PROGRAM IN TWO CALIFORNIA COUNTIES\*

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IN 1939, the Children's Bureau proposed that the development of a diagnostic and medical care program for children with rheumatic fever and rheumatic heart disease be initiated in a relatively small area near medical and hospital facilities. In the fall of 1940, this program was begun in Solano and Contra Costa counties and by 1941, regular diagnostic clinics were set up in the health centers at Vallejo, Pittsburg and Richmond and in the Children's Hospital of the East Bay region. These counties were chosen only because of their proximity to hospital facilities, and not because anyone suspected them of having a high incidence of rheumatic fever.

It is unfortunate that there is still no specific test for rheumatic fever such as the tuberculin, Wasserman, or agglutination tests. In the absence of a specific test, it is necessary to do a complete work-up of each case to rule out other diseases. Often it is necessary to do serial examinations for months before a diagnosis can be made. This procedure is time-consuming, and with the limited personnel in the Rheumatic Fever Program, it does not permit of a mass survey technique such as can be used in tuberculosis case-finding.

The children examined either had a previous diagnosis of rheumatic fever or were suspected of having rheumatic fever or heart disease. Therefore, the figures presented in this report and giving the percentages of normal and functional hearts found, will be small in comparison to those reported in mass surveys.

During the school year, the school physician, school nurses and teachers are alert for any rheumatic fever symptoms presented by acutely or chronically ill children. Children who present requests for rest periods or for relief from gymnasium period or for special transportation are referred to the school nurse for history investigation. If heart disease or rheumatic fever has been the reason for this request, the child is referred to the rheumatic fever clinic, unless he is under the supervision of a private physician.

From the fall of 1941 to July 1, 1944, some 442 children were examined in the four different diagnostic centers. Of this number, 235, or 56 per cent, were found to have either active rheumatic heart fever, rheumatic heart disease, or potential heart disease (meaning those children with a history of having had rheumatic fever but with no discernible heart damage). Fifty children were given deferred diagnoses and are being kept under observation in the clinics until the diagnosis is determined. One hundred and six, or 24 per cent of the children, have normal hearts and in about 33 per cent of these, a functional murmur was heard during at least one examination.

I may say here that all children are examined on at least two different occasions before a diagnosis of a normal heart or functional heart murmur is made.

Nine per cent of the children examined in this group have congenital cardiac anomalies. Seventy per cent of the children in the rheumatic group had their first attack in California, which is evidence that even though these two counties have had a tremendous increase in population because of the war industries, most of our rheumatic fever is not an imported variety from Oklahoma and

\* Read before the San Francisco Heart Committee at its fifteenth annual Symposium on Heart Disease, October, 1944.

From the Rheumatic Fever Program division of the California Department of Public Health.

Arkansas. We have plenty of rheumatic fever in this section of California.

#### PROCEDURE OF EXAMINATION

I would like to describe briefly the examination of a child in the diagnostic clinic. First, his height, weight and temperature are taken by the nurse; then the laboratory work including complete blood count, urinalysis, sedimentation rate, EKG, Kline and tuberculin are done by the technician. Following this, a history of the child's illnesses and the family history relative to heart disease, "inflammatory rheumatism," and "St. Vitus Dance," is taken from the parent. (Except in rare instances, children are not seen for the first examination in clinic unless accompanied by parent or guardian.) I think that a careful history of the consecutive illnesses and the interim state of health often prove to be important clues to the diagnosis of rheumatic fever. The child is then undressed completely and examined. The skin is inspected for erythema marginatum which is easily missed unless the child is unclothed. I have found it in the region of the 7th cervical vertebra where it would have been unobserved if the shirt had only been lifted to listen to the heart and lungs. Subcutaneous nodules are looked for and palpated for along the tendons of the wrist and ankle, over the knuckles, on the elbow, on the scalp. The regular eye, ear, nose, throat and teeth inspection is made. Lymph nodes are palpated.

The regular heart examination including: inspection, palpation, percussion and auscultation is done (auscultation in both reclining and sitting positions). The soft, blowing systolic functional murmur heard in the 2nd left interspace and along the left border of the sternum is usually of different intensity in the two positions, often is not audible in one position while it may be very distinct in the other. An early mitral stenosis may be missed unless listened for in the left lateral position with the bell stethoscope. Most of the murmurs found in children are high-pitched and are best heard with a diaphragm type stethoscope. The arm blood pressure is recorded and if a congenital heart lesion is suspected, the leg blood pressure is also recorded. The abdomen is always examined for the possibility of a palpable spleen and tender liver and for tenderness over appendix. Since abdominal pain is a fairly common symptom in rheumatic fever, both in its acute and chronic forms, appendicitis must always be ruled out, as that, after all, is the cause of more abdominal pain than any other disease. Out of fourteen children now on the rheumatic fever ward at the hospital, two had appendectomies (one normal appendix and one slightly infected appendix) a few days before the development of polyarthritis. Both of these children have a mild valvulitis with no enlargement of the heart.

The extremities are palpated for tenderness which is only occasionally present in the subacute stage, but is a necessary part of the examination in ruling out bone lesions. Very recently a low-grade osteomyelitis was picked up because of one small tender area which was later confirmed by x-ray. This child also has a systolic mitral murmur and a slightly enlarged heart. Does he also have rheumatic fever?

If the child is ambulatory, a fluoroscopic examination of the heart in the anterior-posterior, left anterior oblique, and right anterior oblique positions is done. A dilatation of the left auricle as seen with the aid of barium in the right anterior oblique position is not uncommon in early rheumatic fever even in the absence of a mitral murmur. The results of the tests and examination are evaluated and the diagnosis is made, or deferred. In the subacute and chronic states of rheumatic fever, many of the tests may be normal or so slightly abnormal that only the history and repeated examinations over a period of time will give a diagnosis. The difficulty in

always making a quick diagnosis of rheumatic fever is exemplified by the group of fifty children who have been given a deferred diagnosis.

The sedimentation rate is one of our most useful aids in following the patient with rheumatic fever to determine when the active phase passes into the inactive phase. However, it is a non-specific test and is increased in tuberculosis and osteomyelitis, two diseases from which rheumatic fever must be differentiated. It may be normal in pure chorea, also in decompensation—increasing only when the decompensation has disappeared. It is very frequently normal in those patients who were referred to the clinic with a history of recent vague aches and pains, epistaxis, and excessive fatigue, and of course, occasionally in a patient who has been diagnosed elsewhere as active rheumatic fever. I often wonder if I am treating subacute rheumatic fever or just chronic fatigue—but in either instance the child puts on weight, regains his appetite and the fatigue disappears. Of course, the diagnostic label of "Rheumatic Fever" is not given to such a child unless there is undoubted evidence of the disease. Speaking of fatigue, it is often difficult for the family and sometimes for the family doctor to realize the necessity of prolonged convalescence in a child with a monocyclic type of rheumatic fever associated with a rapid return to normal of that feeling of "well being," which is present as long as the child remains in bed. When the child is released from his bed too soon, the rapidly returning symptoms of fatigue, irritability, nervousness and poor appetite stress the importance of longer convalescence.

The names and ages of all the children in the family are recorded on the patient's "Face Sheet" in the chart.

#### DIFFERENTIAL DIAGNOSIS

Here are some of the diagnoses that have in the last three years been confused with rheumatic fever:

*Poliomyelitis.*—In the acute stage of rheumatic fever, poliomyelitis is often considered because the child with severe arthralgia or arthritis of knees and ankles will not move his legs.

*Osteomyelitis.*—Of one joint or of many joints.

*Tuberculosis.*—Of one joint which was found in a two-year-old boy.

*Rheumatoid Arthritis.*

*Acute Lymphatic Leukemia.*—Was found in a seven-year-old girl on whom a blood count had never been done.

*Acute Appendicitis.*—Which probably could be ruled out previous to surgery by a sedimentation rate.

*Erythematous Lupus.*—Was diagnosed in a thirteen-year-old boy whose onset seemed like rheumatic fever except for the associated rash. He died three months later.

*Primary Tuberculosis.*—Produces many of the same symptoms as are seen in subacute rheumatic fever, and at times repeated tuberculin tests over a period of time need to be done before tuberculosis can be ruled out.

*Trichinosis.*—Ruled out by Eosinophilia and/or muscle biopsy.

*Hypothyroidism.*—Produces fatigue, sometimes rather extreme, with vague body pains. One fourteen-year-old boy wanted to sleep 12-14 hours a day and was complaining of extreme fatigue and muscle pains when walking a moderate distance to school, had a poor appetite and no pcp, was found to have a B.M.R. of minus 26. Adequate dosage of Thyroid produced results which ruled out any possibility of the diagnosis being rheumatic fever.

*Secondary Anemias.*—From other causes, frequently from an inadequate diet or from frequent infections or a series of contagious diseases are difficult to rule out be-



cause secondary anemia is a rather constant finding in rheumatic fever. The children with anemia are more easily fatigued, and have all the attendant symptoms of poor appetite, lack of energy, irritability, occasionally epistaxis. A study of the home situation as to hours of rest which the child has (which includes how many persons he sleeps with) and a dietary evaluation is sometimes needed before the etiological factor is uncovered. A complete pediatric and laboratory examination with adequate follow up are the essentials necessary to case finding in rheumatic fever, whether in private practice or in a service devoted to the diagnosis and care of children who have rheumatic fever.

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## QUINIDINE: IN THE TREATMENT OF HEART DISEASE\*

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IN discussing quinidine as a therapeutic agent in the treatment of heart disease, the dangers attributed to its use are so frequently emphasized that they often overshadow its benefits.

Quinidine is a valuable drug in the treatment of heart disease. Many advocate it as a most valuable agent in the treatment of the acute arrhythmias but caution, and perhaps rightfully so, of its toxic nature. Some warn entirely against its use. Then, there are those who believe the dangers attributed to the use of quinidine are perhaps over-emphasized, and advocate it not only in the treatment of the acute arrhythmias but also in long standing cases of auricular fibrillation.

### MODE OF ACTION

Quinidine is a cardiac depressant. It retards the impulse formation in the sino-auricular and auriculo-ventricular nodes. It slows conduction in the auricles, the bundle of His, and in the ventricles. It lengthens the refractory period.

Quinidine is a potent drug. Like any potent drug used in the treatment of disease, a better understanding of its pharmacological action, its behavior and effects often lessen the dangers of its use and enhances its therapeutic values.

### TOXIC SYMPTOMS

The toxic symptoms and accidents most often attributed to the use of quinidine are nausea, vomiting, diarrhea, tinnitus, vertigo and the more serious effects are cardiac stand-still, respiratory collapse, ventricular tachycardia and emboli formation. Most of these complications are perhaps due to two causes:

- (1) Abnormally rapid absorption of the drug, causing symptoms similar to that of an idiosyncrasy.
- (2) Excessive amounts of the drug being given resulting in toxic effects.

It is well known pharmacologically, to avoid complications and toxic effects of any potent drug, a tolerance for the drug must first be established. To accomplish this, very small doses should be given to begin with, then the sizes and frequency of the doses should slowly and gradually be increased.

Most of the toxic symptoms attributed to the use of quinidine are perhaps due to the method in administering the drug, rather than to the drug *per se*. A patient may

well be able to tolerate a test dose of three grains without any untoward effects. However, repeated doses of six grains or more every four or six hours after the initial dose, may be excessive and cause toxic symptoms. In some instances, it may prove fatal.

### EXPERIMENTAL STUDIES

How rapidly does quinidine reach the blood and heart muscle after the ingestion of the drug by mouth or given intravenously? Does the size of the dose and the frequency of the dose alter the rapidity of the absorption time of the drug by the blood and by the heart muscle? *Length of time quinidine remains in the blood stream*<sup>1</sup>:

(a) In dogs, less than 6 per cent of the drug remained in the blood at the end of seven minutes after single doses, up to 10 grains, were given intravenously.

(b) In patients, the drug reached its maximum concentration in the blood in about thirty minutes after oral administration of single small doses. These findings corroborate the work of Weiss and Hatcher.<sup>2</sup> No evidence of the drug was found in the blood after one hour.

(c) After repeated small doses were given orally to patients, the maximum concentration of the drug in the blood was reached in about one hour. No evidence of the drug was found in the blood one and one half hours after the last dose was given.

*Length of time quinidine remains in the heart muscle after oral administration (Dogs)*<sup>3</sup>:

(a) Single small dose (100 mgm.): The maximum concentration of the drug in the heart muscle (0.046 mgm. per gram of heart weight) was reached in about 30 minutes. No quinidine was found in the heart muscle at the end of four hours.

(b) Single large dose (585 mgm.): The maximum concentration of the drug in the heart muscle (0.209 mgm. per gram of heart weight) was reached in about one hour. It was seven hours before no evidence of quinidine was found in the heart muscle.

(c) Repeated small doses (100 mgm.) given at one hour intervals: The maximum concentration of the drug in the heart muscle (0.105 mgm. per gram of heart weight) was reached in about two hours. It was nine hours before no quinidine was found in the heart muscle.

It will be noted that when the equivalent amounts of a large dose are given in three divided doses, one hour apart, the maximum concentration of the drug in the heart muscle is about one-half the amount and it takes twice as long to accumulate. Fig. 1.

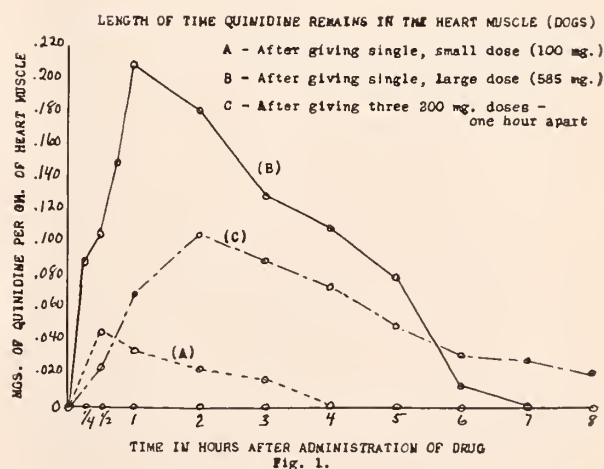


Fig. 1.—Length of time quinidine remains in the heart muscle. (A), After giving single, large dose—585 mg. (B), After giving single, small dose—100 mg. (C), After giving three 200-mg. doses—one hour apart (orally, to dogs).

\* From the Department of Medicine, University of Southern California and the Department of Medicine, Los Angeles County Hospital, Los Angeles, California.

Read before the Los Angeles Heart Association, March 29, 1945.

## CLINICAL STUDIES

*Acute Arrhythmias*.—In the acute or paroxysmal arrhythmias, such as auricular tachycardia, auricular fibrillation, ventricular tachycardia, ventricular fibrillation, etc., quinidine need not necessarily be given in large doses to get the most effective results. Three grain doses by mouth every one or two hours may be given until the heart rate is restored to normal rhythm. Similar doses may be given intramuscularly, as used by Sagall, Horn and Riseman.<sup>4</sup>

*Extra Systoles*.—Quinidine in doses of 0.1 daily or 0.2 daily (0.1 at two hour intervals) is advisable, particularly in cases of chronic myocardial damage. Nathanson<sup>5</sup> has shown that quinidine may prevent increased ventricular rhythmicity (the basis for ventricular fibrillation) and advocates its use in cases of angina pectoris, showing evidence of ventricular irregularities. Morawitz and Hochrein<sup>6</sup> used quinidine as a prophylactic measure to prevent fibrillation and acute heart failure in decompensated hearts. They reported favorable results.

*Chronic Arrhythmias; Auricular Fibrillation*.—The chief objection to the use of quinidine is that the restoration of a fibrillating auricle to regular rhythm may result in the dislocation of an intra-auricular thrombus and the formation of emboli. In 1923, Viko, Marvin and White,<sup>7</sup> discussing the use of quinidine in auricular fibrillation, concluded that the danger of accidents with quinidine is not much greater than with any other form of treatment. Korn<sup>8</sup> in the same year asked whether the cases of embolism from the use of quinidine in auricular fibrillation are more frequent than those which commonly occur in fibrillation treated with digitalis or is it that we hear more by reason of the prominence of quinidine in the medical literature. Many others report similar experiences.

Frick and Kennicott<sup>9</sup> stated it very well when they said, "We are confronted with an unfortunate situation in the treatment of auricular fibrillation, since any treatment that improves the heart action adds to the danger of embolism. It matters not whether the improved heart action is the result of more efficient beats of a heart slowed by digitalization, or a heart restored to normal rhythm through the use of quinidine. One cannot feel that these patients should be denied the beneficent effects of treatment merely because there is a danger of embolism following in the train of restored compensation." They treated eight cases of auricular fibrillation with quinidine, four of which were restored to normal rhythm. One of these patients had auricular fibrillation for four years, and at the time of the writing, two years later, the heart was still regular. One of these patients developed an embolism. Of their forty-three cases of chronic auricular fibrillation treated with digitalis only, there were twelve instances of cerebral or pulmonary embolism.

Kerr<sup>10</sup> in discussing the above paper stated, "There is altogether too much hesitation on the part of many practitioners to use such a valuable drug as quinidine has proven to be. Just as with any other potent drug, we must appreciate the indications for its use and then must give the drug until we have secured the desired effect or until toxic symptoms require the withdrawal of it."

Since 1929,<sup>11</sup> we have treated several hundred cases of auricular fibrillation by the ambulatory method, at the University of Minnesota Cardiac Clinic. Fully 70 per cent of the cases were restored to normal rhythm. The number of accidents compared favorably with any similar number of cases treated with digitalis. We had no known instances of sudden death. There was one case of auricular standstill, with no untoward effects.

Many of our patients were cardiac invalids. They could not successfully carry on with their daily duties. Many were heart conscious due to the palpitation and irregular

beating. Many of these individuals whose irregularity was restored to normal rhythm became fully compensated and returned to their normal duties. Maintenance of normal rhythm depends largely on continuing treatment. Some of our patients have continued on therapy and remained regular for as long as ten years.

## METHOD OF TREATMENT (AURICULAR FIBRILLATION)

1. Digitalize the patient.
2. Heart rate must be slowed down to between 80-70 beats per minute before starting quinidine.
3. After the heart rate has been reduced, keep the patient on a maintenance dose of digitalis (usually 0.1 gm. or 1 cat unit) during the treatment with quinidine.

## Method of Giving Quinidine

Day No.	8:00 a.m.	10:00 a.m.	12:00 noon	2:00 p.m.
1.	0.1 gm. (1½ gr.)			
2.	0.1	0.1		
3.	0.1	0.1	0.1	
4.	0.1	0.1	0.1	0.1
5.	0.2 (3 gr.)	0.2	0.2	
6.	0.2	0.2	0.2	0.2
7.	0.33 (5 gr.)	0.33	0.33	0.33
8.	0.33	0.33	0.33	0.33
9.	0.33	0.67 (10 gr.)	0.67	
10.	0.67	0.67	0.67	

If the patient complains of any toxic symptoms, such as diarrhea, gastric distress, nausea, etc., reduce the dose to that of the previous day, for a few days, then proceed again as indicated.

If the heart has not returned to regular rhythm after giving 30 grains of quinidine for a few days, discontinue its use. I have found that if it takes much more than 30 grains to restore normal rhythm, it is very difficult to maintain a normal rhythm. After the heart rate is restored to normal rhythm, gradually reduce the dose of quinidine in amounts of 5 grains daily until the patient takes about 15 grains daily. The maintenance dose may be 10 grains or even 5 grains daily in some cases. Usually 5 grains for two doses two hours apart is the average maintenance dose. This dose may be kept up indefinitely together with digitalis.

In my previous reports, I recommended giving quinidine at one hour intervals. I still do to begin with. In many instances, however, in view of the studies on the excretion time of the drug, it might, for general use, be advisable to use the two hour interval.

## COMPLICATIONS

Accidents, such as cardiac stand-still, can possibly occur. However, cases of auricular stand-still have been reported due to digitalis. Instances of sudden death have been reported which were probably due to respiratory paralysis. Gordon, Matton and Levine<sup>12</sup> working with cats, showed that respiration ceases one minute or more before the heart stops beating after giving lethal doses of quinidine. We corroborated this finding in dogs. However, it took lethal doses to cause the respiratory paralysis. It is possible, perhaps, for small doses to act as a lethal dose in man.

## CONDITIONS UNFAVORABLE FOR QUINIDINE THERAPY

There are some types of cases of auricular fibrillation that are unfavorable for quinidine therapy, but not necessarily contraindicated. They are, particularly, the mitral stenosis cases with marked cardiac enlargement and the very large hypertensive hearts. These cases are the most difficult to restore to normal rhythm and once restored to normal rhythm are hard to maintain. In auricular fibrillation due to hyperthyroidism, the hyperthyroidism must first be controlled.



Should one give quinidine in cases of auricular fibrillation that give a history of throwing off emboli? Oppenheimer,<sup>13</sup> White and Blumgart,<sup>14</sup> Smith and Boland<sup>15</sup> and others have reported cases of chronic auricular fibrillation and decompensated organic heart disease that were continually forming emboli. The administration of quinidine stopped the emboli formation, restored these hearts to normal rhythm and to normal cardiac compensation. Oppenheimer stated, "We think that the increased danger from embolism during transition from fibrillation to coordinate auricular contractions has been somewhat exaggerated."

White and Blumgart add, "We have herewith reported on two patients in whom the administration of quinidine with consequent return to normal rhythm was undertaken despite generally accepted contraindications. This was followed by abrupt and striking improvement with cessation of pulmonary embolism in Case 1 and congestive failure in Case 2."

Should a slow fibrillating heart controlled with digitalis be restored to normal rhythm? This question is often brought up. Eyster and Swarthout<sup>16</sup> in 1920, experimenting on dogs, showed that the cardiac output in a fibrillating heart was diminished 15-79 per cent. Lewis<sup>17</sup> working on dogs and cats, demonstrated that the minute volume of a fibrillating heart decreased about 20 per cent. In 1930, Smith, Walker and Alt<sup>18</sup> showed that the minute volume increased about 30 per cent when normal rhythm was established in fibrillating hearts that had previously been treated with digitalis. Kerkhof<sup>19</sup> carried on studies in cases of mitral stenosis with auricular fibrillation. He found that the cardiac output increased on the average of 30 per cent after the hearts were restored to normal rhythm. Hirschfelder<sup>20</sup> many years ago, stated the following, "The mechanical effect of any arrhythmia is to slow the circulation. This leads to an increased pressure in the veins and upon a cardiac muscle whose tone is diminished, establishing a vicious circle."

Quinidine is perhaps the choice drug in the treatment of cardiac irregularities. Experiments were done on dogs and on a small number of patients (3) to determine the comparative value of "pure" quinidine (which contains about 7 per cent of the hydro-basis) hydroquinidine and the regular commercial quinidine. The latter contains about 80 per cent pure quinidine and about 20 per cent hydroquinidine. In our small series of 8 cases, treated with hydroquinidine, we found no beneficial effects.

#### SUMMARY

Quinidine is a valuable drug in the treatment of cardiac irregularities. Many of the dangers attributed to its use have perhaps been over-emphasized. To avoid many of the toxic symptoms attributed to the drug, quinidine should be given in small doses to begin with, then gradually and slowly increase the size and number of doses.

Long standing cases of auricular fibrillation are not necessarily a contraindication for the use of quinidine. A fibrillating heart restored to normal rhythm increases the cardiac efficiency from 20 to 30 per cent. In many instances, patients with chronic auricular fibrillation and a mild degree of heart failure, due to the irregularity, may be restored to a reasonable normal activity and a useful existence by regulating the heart's action with quinidine.

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(References continued on page 135.)

## SHORT WAVE RADIATIONS: MECHANISM OF THE ANTI-INFLAMMATORY EFFECT\*

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ON being asked the other day what conditions other than cancer are treated with x-ray, I returned the half-facetious reply, "Acne to zoster and all way points." Half facetious, because although radiologists are often accused of treating uncritically anything at all with radiations\*, and perhaps with a measure of justice, the fact remains that a wide variety of completely unrelated inflammatory conditions respond to irradiation with improvement or cure. Unfortunately the mechanism of this response is rather obscure. The following discussion attempts to cover some of the principal physiological actions of radiations as they relate to this problem.

Bell<sup>2</sup> defines inflammation as "the local defensive reaction that occurs when an injurious agent penetrates the tissues." This definition covers not only conditions caused by bacterial invasion, which we commonly associate with the term inflammation, but also a large group of injuries caused by non-vital agents such as heat, cold, x-rays, ultraviolet rays, contusions, etc. All of the fundamental characteristics of the resulting inflammatory reaction are identical, consisting of vasodilation and increased blood flow to the part, degeneration and necrosis of cells, exudation (a transfer of plasma and leukocytes from within the capillary walls to the tissue spaces), and reaction of the connective tissue cells. There are three possible actions of radiations on this series of events; they may

\* For purposes of this discussion, the general terms "radiation" and "irradiation" will refer to the employment of rays having a wave length of 1A or less; that is, x-rays and gamma rays.

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suppress or prevent the further evolution of this process; they may hasten its course; they may lessen its severity.

*The action of radiations on inflammatory processes* has been variously explained. One of the earliest suggestions was a direct action on the infecting microorganisms. That this explanation is erroneous may be deduced from two facts. In the first place, irradiation benefits some non-infectious inflammatory conditions (such as bursitis, for example) in which no causative microorganisms are present. In the second place, the doses required to kill bacteria in vitro are of the order of 10 to 1,000 times the clinical anti-inflammatory dose. Thus Rahn<sup>17</sup> gives the lethal dose for *B. coli* as 1883r administered in 45 seconds. Russ<sup>19</sup> has demonstrated that while the irradiation of inoculated animals increased their resistance to an infectious disease, identical doses produced no evident effect on the morphology or physiology of the causative bacteria in vitro. Since there is no satisfactory evidence in contradiction, it may be taken that there is no direct bactericidal action under the conditions of anti-inflammatory irradiation, and as for non-lethal effects, the evidence seems against them.

*Effects on the blood stream* have been considered as a possible explanation. The principal adverse argument is the impression that only treatment localized to the lesion is effective. Wintz,<sup>20</sup> however, reports "favorable effects have been observed in non-irradiated infected centers far removed from the treated area." There is moreover the added fact that changes in the blood stream following localized radiation have been demonstrated. Rosselet and Humbert<sup>18</sup> have shown a rise in the opsonic index following small doses of irradiation, the maximum rise occurring with a dose of 75r to 150r; further increase in the dosage led to a progressively smaller rise until at a dose of 300r a fall below control levels was observed. The work of Chambers and Russ,<sup>6</sup> who found a progressive loss of opsonins following alpha radiation of the circulating blood, suggests that this change might be due to an effect on the leukocytes rather than on the blood proper, but they report no effect from beta or gamma radiation. Increase in the blood antitoxic factors has been reported as a result of x-radiation preceding the administration of toxin.<sup>3</sup> The exact converse has also been reported.<sup>12</sup> The dosage levels involved probably determined the response, since doses about 30 to 60 times as large were used in the latter experiments. Hektoen<sup>12</sup> states that massive doses of x-ray after immunization have no effect on the antibody level. Brooks<sup>5</sup> thinks that the experimental work on x-ray effects on antibodies is inconclusive, and that doses up to 5 HED given directly to hemolysins, precipitins, and agglutinins in vitro have no effect. In vivo irradiation has also led to inconclusive results, but he felt a slight protection had been observed. Lusztig<sup>13</sup> reports at least partial inactivation of alexin (complement) by doses of 1/2-4 HED. That a humoral change distinct from immunity changes is present seems to be indicated by the work of Barnes and Furth,<sup>1</sup> who report that irradiation of the lymphoid tissues of one part of the body leads to changes in remote non-irradiated lymphoid tissues. They attribute this to a "toxic factor" liberated in the blood stream. It is difficult to evaluate this evidence but the conclusion seems warranted that although there is a humoral response to irradiation, it is a minor factor in its clinical application.

*Irradiation effects on the exudate*, especially the leukocytes, have been for some years considered the principal cause of anti-inflammatory effects (Pordes and Desjardins have been principally responsible for the popularization of this idea). The extreme sensitivity of lymphocytes is well known, and in the course of their disintegration following radiation injury they liberate anti-bacterial substances which lead to the inhibition or

phagocytosis of the bacteria. Evidence that this action takes place seems well authenticated, but it is open to question that this is the sole, or even the most important mechanism. The fact that no response at all is observed in frank abscess would seem to indicate the leukocytic destruction which takes place is a comparatively minor factor. Moreover, the polymorphonuclear cells which are most numerous in most pyogenic processes are not very radiosensitive; while the highly sensitive lymphocytes are a very small minority. It therefore seems reasonable to believe that this action explains only a small part of the observed phenomena.

*Vascular effects* have only recently been given much consideration as a source of the results of irradiation of inflammations because the small doses used do not give any very well marked vascular change in the intact individual. However, the altered state of the vessels in inflammation makes them more susceptible to radiations. Vascular effects are of major importance. Borak,<sup>4</sup> in a very well reasoned essay, points out the fact that irradiation produces two effects, a dilatation of the capillaries (or "heat-like effect") and a narrowing of the arterioles and venules (or "cold-like effect"). Both of these tend to decrease the amount of inflammation, the first by increasing the transudation of antibodies, leukocytes, and lymph, and the second by reducing the heat and swelling of the part. Since the venules usually have wider lumens than the arterioles, their narrowing produces little circulatory change, that of the arterioles and capillaries being paramount. The increased transudation of lymph tends to increase the flow in the lymphatic vessels, mechanically diluting and washing out injurious agents. The preceding considerations also explain the harmful action of excessive dosage, since an extreme degree of narrowing in the arterioles would impede or stop the circulation, with the result of increasing the total damage.

*Radiations have a number of other effects* which probably are of some importance in this regard. There is a decrease of the permeability of the cell membrane with small doses.<sup>15</sup> There is an increase of cell streaming, which is thought to be due to liquefaction of protoplasm; and this liquefaction has been demonstrated in leukocytes. After irradiation of the entire organism there is an increase in serum globulin and a decrease in serum albumin. And most important, there seems to be an increase in cell metabolism as manifested by increased oxygen consumption and carbon dioxide production. Any of these effects might well have some bearing on the observed total effect of radiations. It is, of course, a matter of grave difficulty to transpose the results of experiment into terms of human tissue reactions; and this coupled with the obscure rôle of the above and similar factors, leaves their importance pretty well in the background.

#### DISCUSSION

The statement is sometimes made that irradiation produces fibrosis and thus interferes with any subsequent surgical procedure. This supposition is based partly on inaccurate observation and partly on misapprehension of fact. It is undoubtedly true that heavy doses of radiation, by destroying the tissues, produce a fibrosis that is nothing more or less than scar formation. Any destructive agent will do this. Non-destructive doses of radiation, however, have the opposite effect; they tend to inhibit fibroblastic activity. Patterson<sup>16</sup> reports loss of axial growth and abnormal cell development with a decrease in mitotic activity in chick fibroblasts in tissue culture following doses ranging from 2,000 to 15,000r. Early and complete recovery followed the lower doses; delayed and incomplete recovery was observed with the higher ones. Immediate death of the culture was not observed in his experiment. Halberstaedter, et al<sup>11</sup> report complete in-



TABLE 1.—On Relative Value of Treatments

Treatment Highly Effective	Treatment Moderately Effective	Effectiveness Doubtful	Treatment Useless or Contraindicated
Adenitis, tuberculous	Arthritis, rheumatoid	Bronchiectasis	Arthritis, late, all types
Adenitis, non-specific	Arthritis, infectious	Cystic mastitis	Pulmonary tuberculosis
Arthritis, gonorrheal	Gas gangrene	Osteomyelitis	
Bursitis	Iridocyclitis	Peritonitis	
Carbuncles and furuncles	Mastoiditis; otitis		
Cellulitis; lymphangitis	Pneumonia, lobar		
Condylomata acuminata	Pneumonia, virus		
Dermatitis and dermatoses	Salpingitis, gonorrheal		
Erysipelas	Salpingitis, tuberculous		
Fungus infections	"Sciatica"; "neuralgia"		
Herpes simplex	Sinusitis		
Herpes zoster	Vernal conjunctivitis		
Parotitis, non-epidemic			

hibition of cultures of rat fibroblasts following doses of 20,000r, and Goldfeder<sup>10</sup> gives 20,000r as sublethal and 25,000-30,000r as lethal dose for chick fibroblasts in vitro. Descending into the clinical range of dosage, Lasnitzki<sup>14</sup> reports a decrease of mitotic activity of chick fibroblasts with a dose of 100r, followed by renewal of the mitotic activity accompanied by an increase in the number of degenerate cells. And the clinical observation that irradiation of scars postoperatively inhibits the formation of keloids is beyond question. Therefore an inhibitory action of radiations on fibroblasts in vivo is certain, showing that the action is the direct opposite of what would produce fibrosis; the fear of a fibrosis resulting from anti-inflammatory irradiation is groundless, not to say ridiculous. It must not be forgotten that an inflammatory process may of itself produce fibrosis; this probably accounts for the cases attributed to radiation.

Summarizing, it appears that the beneficial effect of radiations is a very complex process, depending perhaps on the vascular changes for the principal action, but involving as well effects on the exudate, both cellular and liquid, on the blood stream, on cell metabolism, and possibly on still other processes. It is important that as far as we know now, the entire action is on the host, not on the inflammation-producing agent.

*The crux of successful treatment of inflammations* comes to one thing; proper dose. Heavy doses frequently repeated will make inflammatory conditions worse; yet many, conditioned by their training in cancer therapy, attempt to use just such measures. It can almost be stated as axiomatic that a single dose of 200r is excessive for anti-inflammatory irradiation. The lower limit is by no means so easy to fix. As little as 1r has been recommended for each dose.<sup>7</sup> My personal preference usually fixes the dose between 50r and 100r, and this is a popular region with most therapists. However, the exact dose for an individual cannot be fixed a priori; the more acute the process, the smaller the dose which should be given in any treatment. Too large a dose will more often flare up an inflammation than improve it. The number of treatments and their spacing is very variable; in general, as few treatments as possible should be given, and they should be spaced 48 to 72 hours apart in most instances, although in very acute processes a spacing of 12 to 24 hours may be preferable. As soon as a definite regression begins, treatment should be stopped. A total dose of about 300r in acute inflammations and 600r in chronic ones is generally maximum. Technical factors may be varied widely with but little change in effect. Low voltage and light filtration are preferable, but in the absence of equipment for this technique 200kv. and ½ mm. copper and 1 mm. aluminum filters can be used successfully. In some chronic conditions, such as tuberculous adenitis, the higher voltage and heavier filter are given preference by many experienced radiologists.

For the purposes of this discussion we are not greatly concerned whether irradiation therapy is the best of all possible treatments for any condition. It is sufficient to

note whether irradiation may be of benefit or not, leaving the decision as to whether some other form of treatment might be more beneficial to be decided by the circumstances of the individual patient. Clearly, it is futile to talk about how much a patient would benefit from penicillin therapy if you can get no penicillin; such a patient might be given irradiation with life saving benefit, even though penicillin, were it available, would be preferred. In certain diseases, of course, irradiation is the treatment of choice. Table I lists some conditions which might be considered for radiation therapy, with a rough classification as to their relative responsiveness; the list is by no means exhaustive.

It is apparent from this list that almost any inflammation may be tried on a regimen of irradiation. The criteria for deciding to use this modality are first, that no better form of treatment is available; second, that irradiation has not proven harmful in the treatment of the disease in question; and third, that a therapist with reasonable judgment and experience is available to direct the treatment. The first criterion is obviously a matter subject to individual opinion. But I do not have in mind differences of 1 per cent which can be demonstrated only by the most painstaking and accurate research; I refer to clearly marked out superiorities generally recognized by the profession. In close decisions it is surely the clinicians right to choose that form of treatment which his previous experience suggests as the most effective. Among those who, observing the above criteria, have employed anti-inflammatory irradiation it has won a deserved popularity.

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## WHAT CAN BE DONE FOR THE DEAFENED TODAY\*

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CONSIDERABLE publicity has recently been given to the subject of deafness. As a result there has been a deluge of inquiries by both the laity and the profession regarding this subject. This paper is therefore presented to briefly review the etiology, diagnosis and treatment of the various types of deafness.

### TYPES OF DEAFNESS

A patient with impaired hearing has one of three types of deafness, namely, conduction or middle ear deafness, perception or nerve deafness, or otosclerosis, which is a combination of both middle ear and nerve involvement. Deafness due to malingering or hysteria is not a true pathological entity, and therefore will not be included in this discussion.

### CONDUCTION (MIDDLE EAR) DEAFNESS

*Etiology.* Any pathology that interferes with the transmission of sound vibrations to the inner ear (cochlea and auditory nerve) results in a conduction deafness. This pathology may be present in the external ear canal, the middle ear, or the eustachian tube. External ear canal obstruction is most commonly due to ceruminosis, furunculosis or foreign bodies. The function of the ear drum may be interfered with by a perforation, edema, or by fibrosis (scars). Sound transmission through the middle ear may be impaired due to ossicular chain pathology, such as dislocation, articular disease, necrosis, or by the presence of fluid, either serous or purulent, in the middle ear. Eustachian tube obstruction results in pressure changes within the middle ear and likewise interferes with sound transmission. Tubal obstruction may be due to altitude changes, inflammatory edema, allergic edema or adenoid hypertrophy.

*Diagnosis.* The diagnosis of conduction deafness may be made on the basis of subjective findings, objective findings, tuning fork tests and audiograms. The subjective findings in conduction deafness are quite characteristic. The patient usually has a soft-spoken voice, because external noise interference has been diminished, and he therefore hears his own voice very loudly. In conduction deafness, low tones are not heard, and therefore the patient will state he hears better in a noisy environment. This occurs because other people to whom he is talking

are conscious of the noisy environment and speak with more intensity. Crunchy foods sound very loud to the conductive deaf individual. The objective findings in conduction deafness may reveal external ear, ear drum or eustachian tube pathology. A 512 tuning fork placed in the center of the forehead of a conductive deaf patient will be referred to the ear with the greater impairment, due to the exclusion of extrinsic sounds (Weber test). A 512 fork no longer heard when held one inch from the external ear will be heard when placed in contact with the mastoid bone (Rinne test). A reading taken with the audiometer will reveal loss of air-borne tones.

*Treatment.* Treatment of the patient with conduction deafness depends on correction of the underlying pathology or of furnishing adequate substitution, as the individual case requires. Removal of any external ear canal obstruction is imperative. Correction of any ear drum pathology when possible, such as closure of an old perforation, is very desirable. This procedure is successful only in dry, central perforations. It is accomplished by freshening the edges with a caustic and placing scotch tape over the opening, thus allowing epithelization to occur under the paper. Marginal perforations, unfortunately, cannot be closed in this manner. Conduction deafness due to active middle ear disease necessitates our every effort in an attempt to stop further destruction to the hearing mechanism. If drainage persists in acute otitis media for six weeks, in spite of adequate treatment, it is strongly suggestive of bone necrosis in the mastoid cells. If a prophylactic, simple mastoidectomy is not performed at this time, a chronic discharging ear may result. If the acute ear becomes a chronic discharging ear, a permanent conductive deafness results. If the hearing loss is bilateral and is sufficient to produce difficulty in conversation, then a substitute, such as the artificial ear drum or the hearing aid, becomes necessary.

Artificial ear drums (Pohlman inserts) are indicated in cases of bilateral conduction deafness due to chronic ear disease with partial or total destruction of the ear drum and ossicles. A testing probe is used to determine the sensitive contact point on the medial wall of the middle ear. This area is usually about the oval or round window or over the promontory of the cochlea. When this area is contacted with the testing probe, the patient's hearing will suddenly be markedly improved. The insert of choice is then fitted to the ear canal so as to contact this sensitive area. If this area cannot be contacted by the insert, due to drum or ossicular remnants, an ossicullectomy may be necessary. Artificial drums are of several types, such as the cotton pledget, the cellophane cone, moulded rubber (Korogel) and the diaphragm rod. The choice in a given case depends on the tolerance of the individual, whether the ear is moist or dry and on which insert gives the greater decibel boost in the conversational range of hearing (512 to 2048 vibrations per second). Improvement of twenty to thirty decibels is obtained in selected cases by the use of the artificial drum. In these instances, the results obtained are most satisfactory, in that the necessity for an electrical aid is eliminated and the transmission of normal tone sounds is made possible. The patient is taught to make the artificial drum and to remove and replace it as desired.

All persons with conductive deafness can hear with the magnification of sounds made possible by the electrical aid. When other means fail, the electrical aid serves this type of deafness very well. Its disadvantages, such as the cosmetic effect—with the resultant psychological manifestations, the battery nuisance, and the telephone type of transmitted tone, are well known.

Altitude changes and upper respiratory infections frequently result in obstruction of the eustachian tube, due to edema or accumulated mucoid material. If the tube

\* Read before the Postgraduate Conference of the Alumni Association of the College of Medical Evangelists.



does not open spontaneously, an inflation or two will usually clear the lumen and restore hearing.

Allergic edema of the tube may result in a prolonged bilateral conduction impairment. In these cases, there is usually an associated allergic rhinitis. The deafness is temporarily relieved by inflation and by the subcutaneous injection of adrenalin, as can be illustrated by audiograms taken before and 20 minutes after its administration. The amount used should be just sufficient to produce an increased cardiac action. After the diagnosis of an allergic tubal obstruction is made, a complete allergic study, followed by the necessary desensitization, is indicated in all cases.

*Lymphoid hypertrophy* in the nasal pharynx is a frequent cause of conduction deafness in children. Any child with a conduction impairment without evidence of acute ear disease is entitled to a thorough adenoidectomy. Following surgery, adequate radiation therapy should be given to the nasopharyngeal area to further eradicate every vestige of lymphoid tissue. I have seen cases in this classification obtain a 30 decibel boost bilaterally after such treatment.

#### PERCEPTION (NERVE) DEAFNESS

*Etiology.* Any pathology which interferes with the function of the cochlea or the pathways of the auditory portion of the eighth nerve results in perception or nerve deafness. These include allergy (edema of the cochlea), infection (labyrinthitis), toxemias, drug (alcohol, quinine, etc.), nervous system disease (multiple sclerosis, syphilis, eighth nerve tumors), hemorrhage, industrial trauma (exposure to a continuous noise level) and skull fractures which involve the temporal bone. Congenital malformation of the auditory pathway is not an uncommon cause of nerve deafness.

*Diagnosis.* Subjectively the perceptive deaf patient speaks loudly because he does not hear his own voice. Noisy environments markedly interfere with the patient's ability to hear. Objectively the examination may fail to reveal any evidence of ear pathology. A 512 tuning fork placed in the center of the forehead is referred to the ear of lesser impairment. A 512 fork no longer heard when held one inch from the external ear will likewise not be heard when held in contact with the mastoid bone. Readings taken with the audiometer will reveal loss of both air and bone borne tones in approximately the same degree. In contrast to conduction deafness, high tones disappear first in nerve deafness.

*Treatment.* Generally speaking, the treatment of perceptive deafness is for the most part unsatisfactory. Once the nerve is damaged, it shows little inclination to regenerate, and therefore treatment is directed to prevent further nerve loss. A complete history and a thorough physical examination are indicated in all cases to eliminate every possible underlying cause. The use of massive doses of thiamine chloride has been advocated by many writers. In my experience, the results have been discouraging. The hearing aid is of marked benefit unless the nerve function has been destroyed beyond the point of serviceable hearing. Rehabilitation and the development of the art of lip reading become essential for those with a marked nerve loss. If the loss is congenital, proper speech training beginning in the pre-school age is absolutely imperative.

#### OTOSCLEROSIS

*Etiology.* The pathology of clinical otosclerosis consists of a developmental proliferation of bone involving the area about the footplate of the stapes and the oval window. The exact cause of this proliferation is not known, other than it is hereditary in nature.

The incidence of otosclerotic changes in the labyrinthine capsule is very high and is often found at autopsy in persons never known to be deaf. How many persons go through life with otosclerosis which never manifests itself by involving the stapes footplate is not known, but is estimated at 10 per cent. Otosclerosis accounts for 65 per cent of all deafness in this country.

*Diagnosis.* The diagnosis of otosclerosis may be extremely difficult. Usually otosclerosis is characterized by a progressive bilateral loss of hearing involving first the conductive and later the perceptive mechanism. It becomes apparent in early adult life and is frequently associated with tinnitus. There may or may not be a positive family history of deafness. Frequently the patient has some reason for deafness, such as trauma, childhood disease, or a recent upper respiratory infection. This, unfortunately, may cause the examining doctor to err in the diagnosis of otosclerosis.

A very thorough examination of the entire ear mechanism will fail to elicit any cause for the patient's impairment. The eustachian tubes inflate readily, the ear drums appear thin and translucent, and no apparent pathology can be noted. Interestingly enough, one seldom finds cerumen in the external ear of a patient with otosclerosis.

By the time the patient seeks medical aid, an audiogram will reveal a bilateral conduction loss of twenty-five to fifty decibels, with or without evidence of nerve involvement.

Any progressive bilateral hearing impairment occurring in early or middle adult life, which on examination does not present evidence of ear pathology, very strongly suggests otosclerosis. This coupled with a co-existent tinnitus and a family history of deafness is almost diagnostic of otosclerosis.

*Treatment.* Perhaps no other group of individuals has been subjected to more treatment without benefit than has the unfortunate patient with otosclerosis. Repeated eustachian tube inflations, nose treatments, nose and throat surgery, ear drum massage, various diets, endocrines, vitamins and minerals all have been put through their paces without noticeable benefit. When benefit has been derived, one is led to believe the diagnosis of otosclerosis was in error, for it is difficult when one visualizes the underlying pathology to understand how such therapy could have much reward.

Some seventy years ago an otologist by the name of Kessel had a patient who was suffering from otosclerosis. The patient subsequently heard normally in one ear following a skull fracture involving the temporal bone. Years later an autopsy revealed an open crack in the bone over the patient's intact membranous labyrinth.

This led to considerable experimental work in creating surgically an opening in the osseous labyrinth. It was noted all otosclerotics heard well as soon as this opening was made, providing their nerve function was capable of transmitting the sound to the brain. Likewise, as soon as the bony opening closed, their hearing dropped back to its original level.

Passow, Jenkins, Barany, Holmgren and Sourdille are prominent names in the history of otosclerotic surgery and each made his contribution.

Some ten years ago Doctor Julius Lempert\*\* developed the first satisfactory surgical technique which could be employed routinely in these cases.\* Since then he has modified the procedure on several occasions until now the bony window made over the labyrinth remains permanently patent in some 65 per cent of the cases operated. If the opening closes, it will usually do so within the

\* Ed. Note. For special article on "Fenestration Operation for Deafness," by Robert C. Martin, M.D., see CALIFORNIA AND WESTERN MEDICINE, June, 1945, page 311.

\*\* Fenestra Nov-Ovalis, Julius Lempert, Archives of Otolaryngology, Jan. 1945, Vol. 41, pp. 1-41.

first six months after surgery. Oddly enough, if the opening closes once, the chances are it will close again if reopened. However, because the opening has closed in one ear is no indication it will close if the other ear is operated. We have no way of knowing beforehand which cases are going to close and which will remain open. Considerable research is being conducted at the present time in an attempt to discover some means of keeping the bony opening patent in all cases. Gold burnishing, saucer-shaping the fenestra, metal and cartilage inserts, etc., have all been used, and none has proven infallible.

As one may well realize, surgery of this type is very delicate and exacting. Fortunately the incidence of serious complications is less than 2 per cent. These complications include labyrinthine damage from injury or infection, facial paralysis, meningitis, etc. There have been no deaths directly attributable to the operation up to the present time.

It has been noted the nerve function of the successfully operated otosclerotic seems to remain at its pre-operative level instead of gradually deteriorating, as in the unoperated case. This has not been satisfactorily explained, for it is obvious the surgery in no way influences the disease of otosclerosis but merely short-circuits the involved area so far as the hearing mechanism is concerned. It is thought the progressive nerve loss in the unoperated otosclerosis may be on the basis of a disuse atrophy.

Today the patient with otosclerosis has but one of two choices when the hearing loss becomes pronounced. One is to turn to the hearing aid and the other is the fenestration operation. The hearing aid, within its limitations, will give very satisfactory results in early otosclerosis. Ultimately, if the patient lives long enough and if the otosclerotic process advances to involve the nerve beyond the conversational range, even the hearing aid is of little or no value, and the patient must turn to rehabilitation and lip-reading, just as in the case of far-advanced nerve deafness.

The fenestration operation is indicated in any case of otosclerosis in which the ear drum is intact and the nerve function is capable of transmitting the normal ranges of conversation to the brain. The degree of nerve function present is determined by tuning fork tests and audiometric readings. If the patient has these qualifications, the fenestration operation offers a 60 per cent chance of having serviceable hearing permanently restored. Barring complications, if the fenestra should close postoperatively, the patient's hearing will drop to its previous level. In this event, either the same ear can be reoperated, the opposite ear can be operated, or the patient may turn to the hearing aid and hope his eighth nerve outlives his need for its function.

It is the hope of all of us performing this surgery that some means will be found to keep the newly-created fenestra open in all cases. When this is accomplished, the patient with otosclerosis will have little cause to fear the future.

1136 West Sixth Street.

*Charles Dickens (1812-1870).*—The sickly, sensitive child was father to the restless, overwrought man. Exhaustion, insomnia, failing sight and memory, these were the physical infirmities that burdened Dickens during the latter years of his productive career. In 1864, he became afflicted with a lameness that grew steadily worse. In 1865, he was in a railway accident. Though able to aid those more badly injured than he, he suffered from the shock incurred. In "Edwin Drood" there are unmistakable signs of his dimming faculties.—Warner's *Calendar of Medical History*.

## CLINICAL NOTES AND CASE REPORTS

### SULFAPYRIDINE AS A HEMOSTATIC AGENT

C. RUSSELL ANDERSON, M.D.

Los Angeles

IT is not generally known that powdered sulfapyridine applied locally is a very effective hemostatic agent. In 1942 Cunningham<sup>1</sup> reported on its use. He found that the instillation of sulfamethylthiazole powder in the operative wound after radical external frontal sinusotomy for frontal bone osteomyelitis prevented the usual considerable postoperative oozing. This observation stimulated him to experiment on guinea-pigs. He made circular wounds on the backs of the animals and five to seven days later, he evulsed the scabs so that an open granulating and freely oozing surface remained. Using a powder blower he sprayed powdered sulfapyridine, sulfanilamide, sulfathiazole, sulfamethylthiazole and talc on the wounds. The wounds treated with sulfamethylthiazole and sulfapyridine stopped oozing at once while the wounds treated with the other powders and the control wounds, all continued to ooze for from five to ten minutes. The sulfapyridine and sulfamethylthiazole powders also proved to be bacteriostatic. These results led Cunningham to employ powdered sulfapyridine and sulfamethylthiazole by insufflation in the control of postoperative secondary tonsillar hemorrhage with excellent results.

Stimulated by Cunningham's report, I have used it extensively in a dermatologic practice. Occasionally after electrodesiccation or electrocoagulation of a cutaneous lesion, separation of the eschar will be followed by an annoying persistent bleeding. This is especially so after removal of a carcinoma or keratosis of the lower lip where the frequent movements of the lip tend to prematurely force the separation of the eschar. The application of sulfapyridine powder will instantly control this bleeding. I now routinely apply sulfapyridine powder to all wounds after removal of cutaneous lesions by electro-surgery or cautery. The surfaces of the wounds become hard and dry and heal without infection. The sulfapyridine powder is also very useful in the treatment of bleeding abrasions of the skin.

The use of sulfapyridine powder as a hemostatic agent can be extended into other specialties besides those of dermatology and otorhinolaryngology. The dentist and the general practitioner should find it extremely useful.

1930 Wilshire Boulevard.

#### REFERENCES

1. Cunningham, B. P.: Clinical and Experimental Studies with Sulfapyridine as a Hemostatic Agent, Collected Papers of the Mayo Clinic, 39:12, 1942, Philadelphia, W. B. Saunders Company, 1943.

*Voltaire (1604-1778).*—Born of a tuberculous mother, the great forerunner of the French Revolution, at one time imprisoned in the Bastille, complained throughout his life of a formidable list of maladies which he sometimes used as a shield against his enemies. Excessively thin from childhood, he became a mere skeleton in old age. Yet he was possessed of untiring energy and an extraordinary capacity for work. Poet, dramatist, philosopher. Voltaire remains a commanding figure in literature. When he died only three words were needed on his tombstone: "*Ici reste Voltaire.*"—Warner's *Calendar of Medical History*.



# CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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## OFFICIAL NOTICES

### Proposed Amendment to C.M.A. Constitution Re: Ex-officio Members of Council

*For action taken on this resolution, see below.*

*Be It Resolved*, That the first paragraph of Section 1, Article VII, of the Constitution of the California Medical Association be amended to read:

"The Council shall consist of the Councilors, and ex-officio: The President, the President-elect, the Speaker and Vice-Speaker of the House of Delegates, each with all the rights of a Councilor."

and, be it

*Resolved*, That the first paragraph of Section 4, Article X of the Constitution of the California Medical Association be amended to read:

"The President, President-elect, the Speaker and Vice-Speaker of the House of Delegates shall be ex-officio members of the Council with all the rights of Councilors."

SPEAKER ASKEY: This is an Amendment to the Constitution and By-Laws and must lie on the table for one year and must be published twice during the year in the *Official Journal*. It is so referred to the Association Secretary to be laid on the table and published as required by the By-Laws.

(For reference in minutes of House of Delegates, see JUNE CALIFORNIA AND WESTERN MEDICINE, page 327.)

## COUNTY SOCIETIES†

### CHANGES IN MEMBERSHIP

#### New Members (5)

*San Bernardino County (1)*

Wilson, William H., *San Bernardino*

*San Diego County (2)*

Berry, Herbert Lee, *San Diego*

Lundegaard, E. E., *San Diego*

*San Francisco County (1)*

Ould, Carlton Lee, *San Francisco*

*San Mateo County (1)*

Gish, Rex A., *Redwood City*

#### Retired Members (3)

Coleman, Barney E., *Los Angeles County*

Garrison, J. F., *Los Angeles County*

Hosmer, Charles Morton, *San Diego County*

## In Memoriam

**Baker, Richard Wortman.** Died at Pasadena, August 8, 1945, age 82. Graduate of Beaumont Hospital Medical College, St. Louis, Missouri, 1893. Licensed in California in 1921. Doctor Baker was a Retired member of the Los Angeles County Medical Association, the Cali-

† For complete roster of officers, see advertising pages 2, 4, and 6.

† For roster of officers of component county medical societies, see page 4 in front advertising section.

formia Medical Association, and an Affiliate Fellow of the American Medical Association.



**Campbell, Henry Sutherland.** (Major, United States Army). Died at Los Angeles, July 7, 1945, age 55. Graduate of McGill University Faculty of Medicine, Montreal, 1920. Licensed in California in 1926. Doctor Campbell was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



**James, Lloyd Bertram.** (Captain, United States Army.) Killed on Tinian Island, July 3, 1945, age 39. Graduate of the College of Medical Evangelists, Loma Linda, 1932. Licensed in California in 1932. Doctor James was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



**Murdock, Edgar Paul.** Died at Santa Maria, June 24, 1945, age 60. Graduate of Bennett College of Eclectic Medicine and Surgery, Chicago, 1909. Licensed in California in 1944. Doctor Murdock was a member of the Santa Barbara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

## COMMITTEE ON INDUSTRIAL PRACTICE

### Surcharge Order of Industrial Accident Commission

Acknowledgment of the 15 per cent surcharge order of the Industrial Accident Commission on compensation cases is apparently becoming more prevalent on the part of the insurance carriers in California. Some of the carriers resisted this order at first but have since accepted the Commission's order and adopted the policy of paying the 15 per cent wartime surcharge.

Latest evidence of acceptance of the surcharge order comes from Pacific Employers Insurance Co., which had deducted the 15 per cent surcharge from a physician's statement but paid the full amount when the California Medical Association proposed to take the matter before the Industrial Accident Commission. Payment of the full amount of the statement reemphasizes the stand of the Industrial Accident Commission in backing up its orders; the Commission has stated that it would enforce its order for the 15 per cent surcharge and it has done so when cases of refusal to pay the surcharge have been placed before it.

This latest case serves as an additional reminder that physicians who have been refused the 15 per cent surcharge by insurance carriers can obtain their full fees by placing the facts before the California Medical Association; the Association is prepared to furnish legal counsel for presenting demands for full payment to the Industrial Accident Commission. In each case handled in this way to date the full amount of the fee has been obtained.

The Association is now preparing a new request for adequate medical and surgical fees for compensation cases for presentation to the enlarged Industrial Accident Commission. It has also requested a special interim committee of the State Legislature to enter this subject on its agenda for a full hearing. The C.M.A. Council has authorized its special fee schedule committee (Philip K. Gilman, M.D., Hartley F. Peart, Esq., and John Hutton) to continue its efforts to obtain fair and adequate fees for compensation services. The committee intends

to continue using every avenue of approach in securing an adequate fee schedule, including direct appeals to the Industrial Accident Commission, testimony before the interim committee of the Assembly and conferences with insurance executives.

Correspondence resulting in the latest payment of the full fee, including the 15 per cent surcharge, is reproduced here as an indication of the reasoning impelling acceptance of the surcharge by the insurance carriers.

Pacific Employers Insurance Company  
Los Angeles

Peart, Baraty & Hassard, August 17, 1945,  
111 Sutter Street, Claim No. \_\_\_\_\_

Gentlemen:

Thank you for your letter of August 13, 1945. I am attaching herewith our draft which pays Doctor \_\_\_\_\_'s bill in full in connection with the above entitled matter.

Yours very truly,  
/s/ CHARLES JONES,  
Superintendent of Claims.

Peart, Baraty & Hassard  
Attorneys-at-Law  
111 Sutter Street  
San Francisco, California

\_\_\_\_\_, M. D. August 20, 1945.  
\_\_\_\_\_, California.

Dear Doctor \_\_\_\_\_:

We enclose check No. \_\_\_\_\_ of Pacific Employers Insurance Company to your order in the amount of \$\_\_\_\_\_.

Upon receipt of our letter returning the old check, Pacific Employers forwarded the enclosed. A copy of their letter is also enclosed.

They evidently thought it advisable to pay you the 15 per cent increase authorized by the surcharge order rather than have you file a claim with the Industrial Accident Commission.

In the event this company or any other company should reduce your bill in this fashion again, we would like to hear from you as we feel confident the Industrial Accident Commission will enforce its surcharge order if it is brought before them.

Very truly yours,  
PEART, BARATY & HASSARD,  
/s/ Hartley F. Peart.

### Industrial-Medicine Program in Philadelphia

As an early step in the Philadelphia program, the Philadelphia County Medical Society offered a 48-hour course of instruction on industrial medicine to doctors and nurses. Sixty physicians attended. To them and to the nurses was explained the theme of the project:

"To keep a well worker in every job and to safeguard him so that his working environment cannot strike at his life or his health."

Next, the Pennsylvania State Department of Health made a survey of Philadelphia industries to determine how many of the more than 5,500 manufacturing establishments had medical service. It was found that those with 500 or fewer persons on the pay roll were "woefully ill equipped or completely lacked any medical service."

It was found, coincidentally, that 90 per cent of the city's industrial workers were employed in small plants.

To tell small industry how to tackle a health project, the Philadelphia Chamber of Commerce printed a pam-



phlet. Simply written in question and answer form, and free to all who were interested, the booklet advised these optional plans:

1. Hiring, on an hourly basis, of a general practitioner interested in industrial health, his work perhaps to be supplemented by calls from visiting nurses.

2. Hiring of a physician whose full time is devoted to industrial health and who makes scheduled visits from company to company. Rates for this type of doctor are likely to be lower because the physician, by having only an industrial practice, eliminates such things as office expenses, tardy accounts, 24-hour duty, fluctuation of income, etc.

3. Operation by a physician of a dispensary in a building housing several industries, the dispensary being supported on a *per capita* subscription basis.

4. Opening of a central dispensary in a neighborhood of small industries, the dispensary to be staffed by a physician and a full-time registered nurse.

5. The management of a factory building containing several industries contracts with a physician to supervise a dispensary in space set aside by the management.

As for the very vital matter of costs, the booklet says that they will vary widely according to type of industry, the number employed, accident rate, total of workers exposed to serious occupational disease hazards and, of course, the extent of health services contemplated.

Concerning supplies, the booklet states:

"It has been a matter of experience that in a dispensary not equipped for x-ray and laboratory work, the supplies will cost about \$20 a month for a plant of 100 employees; \$60 for one with 500 employees."

## COMMITTEE ON MEDICAL ECONOMICS

### California State Board of Equalization Changes Ruling Regarding Sales Tax on X-Ray Films

#### Important Notice

California physicians, particularly those specializing in x-ray procedures, have been cheered to learn of the changed ruling of the California State Board of Equalization regarding sales taxes on x-ray films. The Board had originally ordered that sales taxes must be paid on the fair value of films used in x-rays; in some instances the Board had demanded that radiologists take our retailers' licenses and report regularly to the Board on the value of films used in their procedures, collecting sales taxes on these films from their patients and remitting such taxes to the Board of Equalization.

Upon presentation of legal reasoning which pointed out that the radiologists were not in the business of selling tangible personal property but were actually engaged in a professional procedure, the Board changed the original ruling. As the rule now stands, sales taxes are due and payable on the fair retail value of x-ray films *only* where the film is actually transferred in retail trade. So long as title to the film remains with the radiologist, no sales tax is due and payable.

The original Board ruling was apparently made at the insistence of lay radiographic laboratories which undertake to make x-ray plates and deliver them to purchasers without any professional reading, analysis or diagnosis.

*References to article, "Quinidine." Continued from p. 125.*

19. Kerkhof, A. C., and Bauman, H.: Minute Volume Determinations in Mitral Stenosis During Auricular Fibrillation and when Restored to Normal Rhythm, *Proc. Soc. Exper. Biol. and Med.*, 31:168-170, 1933.

20. Hirschfelder, A. D.: Disease of the Heart and Aorta, J. B. Lippincott Company, Philadelphia and London, 1918.

The lay operators claimed a discrimination against their laboratories in favor of physician radiologists who perform a professional service which includes the taking and reading of x-ray films.

Arguments against the original Board ruling were based on the fact that the professional radiologist makes x-ray plates as a part of a professional diagnostic service, that these plates are not sold at retail to either the patient or another physician, even though they may be submitted as a part of an opinion, and that the fee charged by the radiologist is a professional fee for services rendered in a diagnostic procedure. The change in the Board's ruling followed this reasoning. The new ruling holds, in effect, that sales taxes need be paid only where there is a delivery of x-ray film at retail and where title to the film is transferred.

In line with long-established practice, diagnostic procedures do not involve the transfer of title to material aids. The courts have long held that the x-ray plate is the property of the physician and not of the patient. In the case of a radiologist specialist, title to the film remains with the radiologist, even though the film itself may be loaned to another physician as a material aid in diagnosis. The radiologist is still performing his professional function of diagnosis and there is no sale of property.

Radiologists are advised by our general counsel to use an ownership statement attached to x-ray plates or made a part of the transparency. Such a statement would further demonstrate that the plate is the property of the radiologist and is a part of his files. Under the Board of Equalization's new ruling there is no need for the radiologist to take out a retailer's license or to report sales taxes on any portion of his professional fee. (Note. For other reference, see page 152.)

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The Board of Trustees of C.P.S. held its regular meeting on July 15, 1945, in Los Angeles.

The board concerned itself with recent developments in the problems of prepaid medical care which have developed as a result of the legislative session. Aside from the major issue of compulsory health insurance, there were various other bills that were introduced into the Legislature which might have affected the organization of C.P.S. indirectly. The board was advised that most of these had the same fate as the compulsory health insurance bills. Concern was evidenced in the closeness of the final vote and also toward the continued active in-

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Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization through W. M. Bowman, Executive Director.

terest of committees of both the Senate and the Assembly during the coming year.

An interesting report was presented by the liaison member to the board from the C.M.A. on a meeting of representatives of the medical associations of the western states. Of particular interest to the Board of Trustees was the report given by Dr. L. Fernald Foster, Secretary of the Michigan Medical Society, who has had close contact with the creation and the development of the Michigan Medical Service. His report reviewed the difficulties surrounding the development of a medical service plan. It was of great interest to hear the experiences of the Michigan Medical Service from 1939 up to the present time. During this period, there was very little contact between the Michigan plan and the California plan, but the experiences of Michigan as outlined by Dr. Foster were astonishingly similar to those experiences that California Physicians' Service had during the same period of time. The report clearly set forth the fact that the two leading plans of the country—Michigan and California—went through many periods of trial and error, but that the difficulties encountered are not insurmountable where proper evidence of the backing of the medical profession to these plans is present.

In the regular business of the board, it was reported that the month of June resulted in the acquisition of 13,820 new members. The California State Employees' Association alone brought in over 2,100 new members. It is significant that this organization of State employees, which was one of the first groups to join C.P.S., has maintained its membership in increasing numbers since the early beginnings.

It was also reported to the Board of Trustees that over 95 per cent of the membership have been notified of the rate increase, and that as of July 1st, 75 per cent will be paying this increased rate. During the entire procedure of the rate change, there has been a negligible loss of membership due to the change.

It was also pointed out to the board that there are beginning to be indications of increasing labor turn-over, as evidenced by the lapse ratio in membership. At the present writing, due to the war's end, this problem will rank as the major one for the coming year. Its extent and effect upon the affairs of C.P.S. cannot be predicted, but it is logical to assume that it will handicap plans for expansion considerably.

The Fee Schedule Committee which was set up by the Board of Trustees presented its final report. This report indicated that in general the fee schedule was satisfactory to the profession at large, and that no major changes were recommended. Several specific items in the schedule were altered, and many new items included because of change in techniques and procedures in the past year or so. The Fee Schedule Committee has suggested that study be given to the possibility of a differential fee for Diplomates of their Specialty Boards. This was discussed by the board, with consideration of the over-all effect on professional relations and the effect of such a change on C.P.S. from an actuarial point of view. No decision was made, and the subject remained open for further study and investigation.

Reports were given to the board on negotiations that are under way with several large groups and State-wide groups, which is evidence of the interest of this type of organization in acquiring prepaid medical care, and which has been given impetus by recent legislative discussions and the publicity that they provoked.

At this meeting the Board of Trustees was presented with the resignation of Dr. T. Henshaw Kelly. The resignation was accepted with regret.

CHESTER L. COOLEY, M.D., *Secretary.*

## CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

### Information for Medical Officers

With the termination of the war in Europe, many medical officers in that theater are in doubt as to their future assignments. Many physicians have apparently written to the A.M.A. under the impression that that organization could do something about it. The *Journal* says:

"The American Medical Association—and this statement is made wholly in explanation of a fact that should be obvious to everyone—does not have authority to determine in any way the assignments of physicians in the armed forces. The officers of the Association would be hesitant to interfere in the making of decisions as to the assignments or transfer of men in the armed forces. The decisions as to how military personnel are to be utilized must rest with those who carry the responsibility for the ultimate results. This statement is made because many a medical officer has written to the headquarters of the American Medical Association actually demanding that the Association exert its influence to determine the decisions, not only to those responsible for the medical departments of the armed forces, but even of the Secretaries of War and Navy, of the Committees on Military Affairs of the legislative bodies, and even of the President. The Board of Trustees and the Officers of the Association have felt keenly, nevertheless, the responsibility that rests on them to present to those in authority the facts that should be given serious consideration in the making of decisions concerning medical personnel."

Some physicians have also written to the A.M.A. protesting against the possibility that they may be assigned on their release from service with the armed forces to the Veterans Administration. On their behalf, the A.M.A. Committee on Postwar Medical Service on May 12 took prompt action and sent to the Secretary of War, the Secretary of the Navy, and the Committees on Military Affairs of the House of Representatives and the Senate the following:

"In November, 1944, the Army Medical Department was directed to transfer at least three hundred medical corps officers to the Veterans Administration, this number to include those officers in the zone of the interior who were formerly employed by the Veterans Administration as civilians. Apparently about one hundred men meeting the latter classification were so assigned and in addition some two hundred others selected largely from among men who had been marked 'limited service.' Many of those thus assigned have protested and others are now protesting bitterly against these assignments on the ground that their enlistment was distinctly for military service and that assignment to the Veterans Administration cannot be thus characterized. Many physicians who have served with distinction in both the European and the Pacific theaters of operation are now indicating by communications addressed to the headquarters of the American Medical Association the fear that they may be assigned on their return to the United States to service with the Veterans Administration. The unwillingness to serve with the Veterans Administration is based not only on their belief that this cannot be considered military service but also on the point of view that competent, scientific medical care is difficult under the conditions that prevail in the veterans' hospitals.

"The Committee on Postwar Medical Service, which includes representatives of the American Medical Association, the American College of Surgeons, the American



College of Physicians, the American Hospital Association, the Federation of State Medical Licensing Boards, the Association of American Medical Colleges, the Catholic Hospital Association, the Advisory Board of Medical Specialties, and many other groups, after careful consideration of the problems involved, urges that the Secretary of War, the Secretary of the Navy, and all others concerned with the activities of physicians voluntarily enlisted in the armed forces recognize the righteousness of the protests made by these medical officers against assignment to the Veterans Administration. It is further urged that the needs of the Veterans Administration for physicians be met either by voluntary enrollment of men in the armed forces at the time of their release from the service or by recruitment of medical personnel from civilian sources."

It is quite understandable that many physicians, under the circumstances, would be unwilling to serve in the Veterans Administration not because they are reluctant to care for the veteran but because, as stated, and as seems to be borne out by recent allegations from many sources "competent, scientific medical care is difficult under the conditions that prevail in the veterans' hospitals."

Surgeon General Kirk, in a telegram to the A.M.A., has stated

"The policy of the War Department and of my office is that when medical officers are returned to the United States on rotation or redeployment they will be assigned to duty according to their specialties. They will replace officers with similar qualifications who have not had opportunity for foreign service."

This information should answer some of the questions being asked by medical officers. Reassignment and redeployment is a function of the office of the Surgeon General.—"New York State Journal of Medicine," Vol. 45, No. 15.

### Medical Officers' Discharge to be Based on Point System

*Establish Definite Score for Scarce and Non-Scarce Specialists; Officers With Rating of 100 Eligible For Release*

The Office of the Surgeon General, U. S. Army, announced recently, as reported by *The Journal of the American Medical Association*, a point system for the discharge of medical officers.

The August 11 issue of *The Journal* says that the separation plan of the Surgeon General, drafted after several months work, had to deal not only with numbers but also with classes of personnel.

"On the basis of detailed studies," the Surgeon General's announcement said, "it was decided that it would be best to establish two classes—one for scarce specialists, the other for non-scarce specialists and general duty officers—and to set a definite score for each, so as to keep under strict control the outflow of scarce specialists." . . .

To deal with the separation problem for medical officers, the Surgeon General established a representative Separations Board. . . .

The Board decided to establish definite criteria for separation subject "to the limits of military necessity which governs all discharge policy." It stressed the fact, however, that "these criteria create no vested right in any officer to discharge, but constitute the goal to be sought," then added: "Such necessity may arise from the possible need for a relatively few officers with irreplaceable experience whose usefulness is so great as to transcend individual consideration."

*The criteria for separation from service follow:*

1. Medical Corps officers returned by a theater or declared surplus by a major force (except those with pri-

mary military occupational specialties listed in paragraph below) are eligible for release from active duty if their Adjusted Service Rating is 100 or above.

2. Medical Corps officers in certain scarce military occupational specialties are eligible for release from active military duty if they have an Adjusted Service Rating of 120 or more: Gastroenterology, Ophthalmology and Otolaryngology, Cardiology, Dermatology, Allergies, Anesthesia, Neuropsychiatry, Neurosurgery, Thoracic Surgery, Plastic Surgery, Orthopedic Surgery, Clinical Laboratory.

3. Medical Corps officers over 50 years of age, irrespective of their specialty classification, are eligible for relief from active military duty if they are returned to the United States by a theater or declared surplus by a major force.

4. No Medical Corps officer with an efficiency index of 41 or more who desires to remain on active military duty will be relieved, irrespective of age, military occupational specialty or Adjusted Service Rating.

The Board explained that paragraph four is "in keeping with the spirit of readjustment regulations which provide that individuals who desire to remain on active duty will be given every consideration."

Continuing, the announcement said:

"Because of the fact that the general hospitals in the United States are now at peak and because the Surgeon General desires to send replacements to the Pacific as quickly as possible, the age provision is not being put into effect at the moment for personnel in the Army Service Forces, and no Medical Corps officers in the non-scarce category is being released who has less than 110 points (except those who returned from overseas since V-E Day). However, it is hoped that when more of the surplus personnel is returned from the European and Mediterranean theaters, this temporary expedient can be lifted. . . .

"These are only general rules and are subject to exception in any case due to military necessity, and to change if subsequent developments should make such action necessary. They are not to be understood as creating any right in an officer to continue on duty in this country if military needs now or later should require his assignment to other duty. . . .

### Streptomycin Being Studied

A new drug, streptomycin, companion to penicillin as a killer of bacteria is being studied and undergoing tests by the Army Medical Department to determine its suitability as a germ killer in saving the lives of wounded and sick American soldiers.

The new drug shows possibilities which may prove to be as important to the medical profession as was the discovery of penicillin. Streptomycin is a killer of gram-negative bacteria, such as tuberculosis, cholera, dysentery, typhoid, tularemia and salmonella food poisoning. Penicillin is a killer of gram-positive bacteria, such as pneumococcus, streptococcus, staphylococcus, gonococcus and syphilis.

The new drug is still in the laboratory stage.

Streptomycin and penicillin resemble each other in many respects. Experience gained in the production of penicillin will aid materially in the production of the new drug. The production process, however, is slow and tedious and it will be some time before the drug is available in any quantity. It took more than two years to bring penicillin into production for general use.

Dr. Selman A. Waksman of the Department of Microbiology of the New Jersey Agriculture Experimental Station at Rutgers University, New Brunswick, New Jersey, is given credit for the discovery of streptomycin. Ever since the discovery of penicillin, Medical Department and civilian bacteriologists as well as Army and commercial laboratories have been searching for a drug that would fight the diseases that penicillin cannot cure. Dr. Waksman reported that he had discovered streptomy-

cin and had reported on it some twenty-nine years ago during experiments with soil bacteria.

### 3,000 Fliers Lost in B-29 Attacks on Japan

Guam, Aug. 17 (AP).—General Spaatz disclosed today that the year long operations of B-29's against Japan cost the lives of over 3,000 American fliers, while more than 600 others were rescued by naval operations.

Combat operations resulted in the loss of 437 of the Super Fortresses. Noncombat losses were not announced, but they are known to be considerable, particularly in the early months of the campaign when the crews were learning the capabilities of their planes.

Crews lost, averaging eleven men each, numbered 297....—San Francisco *Call-Bulletin*, August 17.

### Military Surgery Volume Proposed

A group of the best manuscripts dealing with military surgery are being compiled by the Surgical Consultants Division of the Office of the Surgeon General for the information of surgical officers in Pacific Theaters of Operations.

The selection of the papers to be used will be made from those that have been prepared by Medical Corps officers and submitted to the Division for review and approval for publication.

It is anticipated, when compilation of the papers is completed, that they will be offset printed and contained in a single volume. Upon completion of the volume it is planned to distribute copies to medical installations in the Pacific.

### U.S. Army Casualties 161,839 Against Nips

Washington, Aug. 11 (AP).—The war against Japan cost the Army 161,839 casualties up to the early part of June, the War Department disclosed today.

A breakdown on casualties by theaters as reported to June 30 and reflecting fighting through early June showed total casualties of 912,390.

The 161,839 casualties, including 35,810 dead, were suffered in the Alaska, China, India-Burma and Southwest Pacific theaters and Pacific Ocean areas.

The breakdown:

	Killed	Wounded	Missing	Prisoners	Total
Alaska .....	769	922	45	10	1,746
Caribbean (including South Atlantic) ..	51	9	0	1	61
China .....	94	83	145	38	360
European ....	116,044	369,160	14,126	76,378	575,708
*India-Burma (including China-Burma- India prior to Nov. 1, 1944	1,671	2,256	981	-317	5,225
Mediterranean	38,174	106,932	6,015	19,978	171,099
Middle East ..	1,212	571	250	1,650	3,683
*Pacific Ocean areas .....	9,725	31,619	4,050	102	45,496
Southwest Pacific (including 1941-1942 action in Philippines .	23,551	54,582	13,196	17,683	109,012
TOTAL .....	191,291	566,132	38,808	116,157	912,390

\* Twentieth Air Force casualties previously included in India-Burma theater, now included in Pacific Ocean areas.—San Francisco *Call-Bulletin*, August 11.

### Plastic Artificial Eyes

Thirty installations, twenty-nine general hospitals and one regional hospital have been designated plastic eye centers for the Army Medical Department.

As of June 30, 1945, approximately 5,100 plastic artificial eyes have been made and fitted. In addition, the plastic eye laboratories have made conformers, eye spheres and other appliances for the eye clinics.

Experimental work is still being carried on in the plastic artificial eye program. Technicians are continually endeavoring to improve and give these plastic eyes greater mobility and lessen abrasion.

### Letter from Los Angeles Member on Okinawa Experience

(COPY)

August 4, 1945.

Editor George Kress, M.D., *Addressed.*

We just arrived in the States from New Guinea and Manila and received your letter with galley proofs, which I am returning. We will be here only about 1½ weeks—quick combat load and out for another invasion which I hope is "the Main Stuff."

... I had a hard workout at Okinawa—when final reports of fleet showed that our ship's hospital received one-fourth of all serious fresh casualties during first week of invasion embarked there. Our ship unloaded the famous 6th Marines "Raiders" from Guadacanal—on Okinawa on Easter Sunday, April 1st—the first ships to hit the beach and then we stood in close only 300 yards off "Red Beach." *Thus the reason for us* receiving so many operative belly, brain and compounded bone cases. It was rather a workout for me since I was *alone* on board for the surgery, since I had all lieutenant "junior grade"—young doctors just out of naval internships, to help out. Temporary medical personnel ordered to our ship just for this invasion were also junior grade lieutenants just out of internship, but fine, coöperative and hard-working doctors. After operating continuously all night and under air attack, at 4:30 A.M., I was "completely shot" so simply had to get 2 hours rest before operating a belly case of a Marine Captain, sent to us in desperate shock—shot twice through pelvis—belly and with complicating picture of compression, comminuted fractures of low spine with one bullet still in spine, and complete paralysis of both feet. He had previously been found lying in a stream of water for 7 hours, on Okinawa. After hours of transfusion—adrenalin—caffeine (blood count 2 million reds) his condition improved, so I felt safe to open belly. By grace of God he lived, and later we were able to reduce his fractured spine in a dorsal extension sling—body plaster cast—and got him off our ship a week later in cast. Found out that he arrived in States O.K., via air transport plane. For my brain operation (compound skull with avulsed dural membranes and brain tissue with depressed bone fragments) I was wishing for Carl Rand or Raney, but realized I was not at County or Good Samaritan Hospitals in Los Angeles, so just had to go to it anyway. My scientific paper on these cases is back in Washington now—along with bullets and Jap shrapnel.

Best wishes,

(Signed) OFFICER IN U.S.N.R.

### Pacific Medical Conference

One of the most important medical meetings of this war was held in the Office of The Surgeon General, Washington, D. C., on July 30, 31, and August 1, and was attended by outstanding experts in surgery, medicine and disease control from all theaters of operation throughout the world.

Major General Norman T. Kirk, The Surgeon General, called the meeting "to pool the knowledge and experience of the men from the fighting fronts in order that the lessons learned thus far in the war can be more



thoroughly applied than ever before in the conservation of human life."

In addition to about forty of the country's leading medical experts from the overseas theaters, General Kirk had officers from virtually every division and branch of the Office of The Surgeon General attend the meetings and thoroughly discuss all phases of medical and surgical care, supply, transportation, training, and related subjects.

Such problems as the redeployment of millions of men to the Pacific areas were discussed. It was pointed out that the transfer of such vast numbers of American troops will invariably present health problems, but does not make the job impossible or unnecessarily difficult because of the experience of three and one-half years of facing and successfully fighting and controlling disease hazards of these areas.

More effective means for the treatment and care of both wounded and sick troops near the front was another principal question studied at the meeting. It has been proven in the campaigns to date that such care has paid great dividends in the saving of lives and the alleviation of suffering, and the methods used are to be extended as far forward and as rapidly as is humanly possible.

Prevention and treatment of tropical disease were among the major problems studied and discussed at the meeting. Medical Corps specialists declared, however, that because many of these diseases are unknown in the United States a dread of them has been created out of all proportion to their actual harmfulness.

The problem of returning medical personnel who have served several years in Pacific areas to the United States and replacing them with personnel from this country and the European and Mediterranean Theaters was given special study.

"Many of these men have well earned their relief from duty there and many are eligible for discharge," General Kirk said. "As rapidly as replacements can be sent, these men will be returned to the United States."

He added, "From the lessons learned thus far we believe that front line medical care and the prevention and cure of disease can be perfected and the men meeting here know best how it can be done. Insofar as is humanly possible no mistake made before will be repeated."

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

### 1945 California State Legislation

Commenting under this caption, the August magazine of the California State Chamber of Commerce prints the following item:

#### HEALTH INSURANCE

Nineteen different bills were introduced proposing various forms of prepaid medical care, compulsory health insurance, etc. Although major bills were closely contested on a number of roll calls, not a single one of these measures was passed by the Legislature. Both the Senate and Assembly created special interim committees, with a total of \$70,000 for expenses, to study further these questions of prepaid medical and hospital care, health care, etc.

### Survey is Made of Interim Committees of California Legislature

The selection of members to serve on interim committees of the two Houses of the California Legislature, which will make independent studies of State health insurance programs has aroused considerable speculation as to the political philosophies that will be represented

by those chosen to the groups. On the basis of past records it is generally felt that the Assembly committee is definitely loaded with opponents of the philosophy of State health insurance. The Senate group, on the other hand, is regarded as being closely divided, and possibly somewhat favorable to such plans.

Chairman of the Senate interim committee on health insurance is Senator Byrl Salisman of Palo Alto. Senator Salisman was the author of the health insurance bill sponsored by Governor Earl Warren, which was presented to the Upper Chamber at the 1945 legislative session. Despite this fact, however, he is regarded as being the least certain member of the group.

Also on the Senate committee are Senator John F. Shelley, of San Francisco, who was the author of a modified Rhode Island health insurance bill presented at the 1945 session, and who is definitely counted among the proponents of the State health insurance philosophy, and Senator Chris. N. Jespersen, of Atascadero, who supported State health insurance legislation during the past session.

The members who are counted on to oppose public health insurance legislation before the Senate committee are Senator L. G. Sutton, of Maxwell, who represents a farming area and who opposed such bills in 1945, and Senator Arthur H. Breed, Jr., of Oakland.

It is generally considered that the committee is about evenly divided in its composition and that Senator Salisman will be the member to hold the balance of power.

On the Assembly committee the balance against the State health insurance philosophy appears to be decisive. Chairman of the committee is Assemblyman Ernest R. Geddes, of Pomona, a freshman legislator who consistently voted against State health insurance measures at the 1945 session. Other certain opponents of such legislation are generally believed to include Fred H. Kraft, of San Diego, who was chairman of the public health committee during the 1945 session and who opposed all health insurance bills; Sam L. Collins, of Fullerton and John W. Evans, of Los Angeles, both of whom opposed all State health measures.

The remaining three members are regarded as being more doubtful in their position, as a result of a study of their votes in the 1945 session. Assemblyman J. G. Crichton, for example, voted against both the compulsory health bills of Governor Warren and of the C.I.O., but supported A.B. 2201, the hospitalization bill. Assemblyman Ernest R. Debs, of Los Angeles, was among those who voted favorably on the compulsory health bill of the C.I.O. The remaining member, Assemblyman Vincent Thomas, of San Pedro, voted for both the C.I.O. bill and the hospitalization bill.

All observers agree that the past votes of the committee members are not infallible standards by which to measure their attitudes, and that both committees are evenly divided so that anything could happen. . . .—San Francisco *Underwriter's Report*, August 2.

### Medical Service, Insurance Free to School Pupils

The cost of securing medical or hospital services, or accident or liability insurance for the protection of school children while in school buildings or other school premises, is to be borne by the school district and neither the pupils nor the parents can be assessed for such costs, Attorney General Robert W. Kenny, head of the State Department of Justice ruled in an opinion.

His decision was directed to Thomas Whelan, district attorney of San Diego county, who requested Kenny's opinion on the constitutionality of a recent amendment to the Education Code.

"Such medical and hospital services and accident insurance," Kenny stated, "are afforded school districts

employing less than five physicians as full-time supervisors of health."

He pointed out that the education code provides for similar coverage for pupils of school districts injured while participating in athletic activities which are under the supervision of school district authorities. This cost, he said, is authorized to be paid from the school district funds.—Broderick *Independent*, July 12.

### Time to Act!

There have been countless schemes proposed to provide nationwide medical and hospital services on a scale never before dreamed of. Granting that the motives behind all such efforts are sincere, the fact remains that neither money nor laws alone can buy health. American doctors have been giving our nation improved medical practices at a rate not equaled elsewhere in the world. But they now face conditions beyond their control.

The March 10 issue of the *Journal of the American Medical Association* points out that "the Council on Medical Education and Hospitals has repeatedly urged the necessity for changes in the present policies of governmental agencies, including the Selective Service System, having to do with the education of pre-medical students." It shows how the regulations now in force threaten the supply of doctors.

Official notice of this threat is now taken by Senator Allen J. Ellender of Louisiana, who has introduced Senate Bill 637 which includes provisions for deferment of an adequate number of pre-medical students, and for the deferment of such numbers of medical students as will be sufficient to supplement civilian sources of students to assure full classes.

It is evident that unless something like this is done, not only the Army and the Navy, but our civilian population will face a dangerous shortage in medical men. The profession is now being depleted by about 4,000 deaths and an unknown number of retirements annually.

Competent doctors cannot be created in a day, and we will be showing poor gratitude to returned veterans who are injured, if they find a scarcity of competent doctors to meet their needs, not to mention the importance of such doctors for our civilian population.—San Francisco *Western Underwriter*, June.

### Compulsion Is Not Freedom—Re: Compulsory Health Insurance

In the bill before Congress to broaden the Social Security Act to give everyone protection against "the slings and arrows of outrageous fortune" from childbirth to the grave, the word "compulsory" is shunned like the odiferous aroma of the lowly skunk. Nowhere is that word used in any discussions by the promoters of the bill. The public is actually made to believe that everyone will have complete freedom in choice of a doctor, and that doctors will have complete freedom in choice of patients.

It is claimed that State medicine is not socialized medicine. This is about as logical as to say the bill is not compulsory, when the wording of the bill forces all employees drawing up to \$3,600 a year to pay 4 per cent of their earnings into the Social Security fund, and all employers to pay a like amount.

When Government goes into business, that is Socialism, so when the Federal Government establishes a system of insurance to which everyone must contribute, when it regulates the provisions of medical service through Washington headquarters, when it regulates fees that doctors are to receive when they participate in the system, when it regulates those who are to be consultants

and when consultants are to be consulted, that is definitely socialized medicine. The doctors who are dissatisfied with the system can quit and turn their abilities to some other channel, but the people, once they are saddled with compulsory medical practices, are the losers, and they will definitely have to pay for socialized medicine even though they prefer a private doctor.—Editorial in *Palo Alto Citizen*, July 27.

### Law Makers Listen to Voice of Farm Bureau

Under the above caption, Modesto *Tribune* of August 10, gave the following:

The power and influence of the Farm Bureau, particularly in the legislative field, is indicated in the fact that 20 of the 27 issues presented to the Legislature this past session have been written into the laws of the State.

Milton L. Kidd, President of the Stanislaus County Farm Bureau, pointed this out at a recent Farm Bureau meeting, following a report made by Dr. Von T. Ellsworth, research director and legislative representative for the California Farm Bureau Federation. According to Dr. Ellsworth, two of the measures specifically sponsored by the Federation failed of signature by Gov. Earl Warren, and five were defeated in the Legislature.

This Farm Bureau legislative victory is only a part of the story, Dr. Ellsworth said, for it does not include the hundreds of measures supported, amended or opposed by Farm Bureau.

Farm Bureau measures which lost out included those pertaining to: Voluntary Health Insurance; Use of County Hospitals; Repeal of Daylight Saving; Farm Representation on Fair Boards; An Insectory at the Riverside Experiment Station; Fictitious Mortgages.

### Recent Legislation Involving California State Department of Public Health

Attached is list of bills favorably acted upon by the Governor which are of special interest to the State Department of Public Health.

These bills become effective September 15, 1945.

#### Assembly Bills Approved 1945 Session

Bill Number	Chapter Number	
A.B. 112	1373	Clinical laboratories, lawful to accept test assignments from person licensed in any healing art.
A.B. 226	1027	Structural pest control, regulation of.
A.B. 237	601	State tuberculosis subsidies where patients are placed outside county hospital.
A.B. 239	271	Assessment proceedings for sanitary sewers.
A.B. 274	710	Child care centers.
A.B. 302	979	Penalties for violations of Chap. 6, H & S Code, and permitting charges by cities or cities and counties for use of sanitation and sewerage systems.
A.B. 321	602	Provisions of marriage licenses to be filed with County Clerk in County where license was issued five days after ceremony.
A.B. 361	131	Relating to institutions providing housing for aged persons. Nothing to prohibit adoption of rules by local authorities governing sanitation, health and hygiene.
A.B. 362	132	Relating to institutions for child care. Nothing to prohibit adoption of rules by local authorities governing sanitation, health and hygiene.
A.B. 527	957	Relative to annexation of property for pest abatement districts.
A.B. 543	722	Health service for public school pupils. Includes pupils in high schools.
A.B. 580	578	County Health officer to advise on medical matters relative county pension or retirement system.
A.B. 601	1418	State Department of Public Health to



		license hospitals and adopt regulations governing same.					vide for the creation, organization and government of water conservation districts."
A.B. 677	1237	State Department of Public Health to make necessary rules governing sanitation of bakeries; providing penalty for violation. Employees or other persons affected with diseases enumerated are prohibited from working in such bakeries or delivering products therefrom. Water for mixing dough in bakery products if taken from well shall be certified to by State Department of Public Health or city or county health department.	S.B. 478	1005	State Director of Public Health shall be State Registrar of Vital Statistics, and provides that certified copies of birth and death certificates may be issued in short form.		
A.B. 815	1243	Designation of costs for educating physically handicapped children.	S.B. 521	1099	Relative to sites for garbage or rubbish or other disposal plants.		
A.B. 964	1477	Appropriates \$280,000 to State Department of Education for operation of the State cerebral palsy schools—one in Northern California and one in Southern California in connection with cerebral palsy diagnostic and treatment center to be operated in Northern California by the Regents of the University of California, and in Southern California by the governing board of a public or private medical school of a university with which the State Department of Education contracts for such service.	S.B. 577	1208	Amends Food Act, technical changes.		
			S.B. 579	1057	Provides that burial permits or removal permits from local registrar outside the State must accompany bodies brought into California for burial.		
A.B. 965	1516	Appropriates \$154,000 to State Department of Education contracting with the Regents of the University of California in Northern California and with the medical school of any public or private university or hospital in Southern California to operate and maintain cerebral palsy diagnostic and treatment center in connection with two State cerebral palsy schools—one in Northern California, one in Southern California.	S.B. 581	1209	Amends Cannery Act; exempts operation of non-commercial canning centers.		
			S.B. 582	971	State Department of Public Health may maintain a mental health service.		
A.B. 1218	743	State Board of Public Health to register school audiometrists.	S.B. 586	932	"The Local Hospital District Law" provides for organization, incorporation and management thereof.		
A.B. 1219	814	Adds school audiometrists and chiroprapists to list of persons permitted to supervise the health and physical development of pupils in the public schools.	S.B. 636	409	Organization of mosquito abatement districts by Boards of Supervisors.		
A.B. 1310	1337	Repeals Sections 5461 and 5464 of the H & S Code affecting certain of the mechanics of the operation of sanitation districts.	S.B. 651	1060	Exempts laboratories licensed by U. S. Public Health Service or licensed by Bureau of Animal Industry of U. S. Department of Agriculture from the provisions of the H & S Code relating to biologics.		
A.B. 1427	1196	Amends H & S Code, Drug Act; authorizes inspectors, State Bureau of Food and Drug Enforcement to assist in enforcement.	S.B. 705	705	State Board of Public Health and State Department of Public Health included in agencies where administrative procedure is to follow Government Code.		
A.B. 1523	1433	Appropriates \$200,000 for State Department of Public Health for purchase of real property in the San Francisco Bay area for the Department of Public Health postwar building program.	S.B. 729	891	Administrative procedure in suspending or rejecting cannery licenses, clinic and dispensary licenses.		
A.B. 1812	1508	Creates a Board of Social Work Examiners of the State of California under the Department of Professional and Vocational Standards. Provides for registration and use of letters, "R.S.W."	S.B. 730	892	Hearings on violation of the Non-Profit Hospital Service Act to be in accordance with Government Code.		
A.B. 2191	1332	Education of minors in tuberculosis wards, hospitals or sanatoriums.	S.B. 811	1389	Amends California Resort District Act to have powers of sanitary district in unincorporated areas.		
			S.B. 812	1390	Includes "resort districts" in definition of cities under Section 5005 of the Streets and Highways Code.		
			S.B. 813	1391	Includes "resort districts" in definition of streets under Section 5014 of the Streets and Highways Code.		
			S.B. 830	975	Provides for information on birth certificates when time and place of birth are unknown.		
			S.B. 935	1015	Covers the cleaning of septic tanks, cesspools, seepage pits. Registration of operator. Health officer to act on application within thirty days of filing.		
			S.B. 1014	1367	Amends "Crippled Children's Act" relative "residence."		
			S.B. 1015	1368	Amends "Crippled Children's Act" providing that Boards of Supervisors shall appropriate not less than one mill on each dollar of taxable property for the care of handicapped children.		
			S.B. 1020	1519	Appropriates \$400,000 to State Board of Education for purchase of sites, construction of building, etc., for two cerebral palsy schools—one in Northern and one in Southern California.		
			S.B. 1021	1520	Appropriates \$80,000 to State Department of Public Health for physically handicapped children suffering from cerebral palsy.		
			S.B. 1022	1521	Appropriates \$40,000 to State Department of Education for coördination of education of physically handicapped minors in public schools and in cerebral palsy schools.		
			S.B. 1283	1351	Sanitation districts formed under Section 4704, H & S Code, not subject to the "District Investigation Act of 1933." This section effective until the 91st day after final adjournment of the 1947 Legislative session.		
			S.B. 1302	1024	Creates the California State Disaster Council.		
			S.C.R. 57	120	Provides that the State Department of Public Health shall investigate the problem of provision of human blood and derivatives of human blood to the people of the State and that the State Department of Public Health report the results of its investigation with recommendations to the 1947 Legislature.		

## Senate Bills Approved 1945 Session

Bill Number	Chapter Number	
S.B. 25	1447	Increases subsidy from \$3.00 to \$7.00 for persons suffering from tuberculosis.
S.B. 161	404	Amends H & S Code relative to auto and trailer camps in counties having a population less than 900,000.
S.B. 248	661	An act to amend Sections 10615 and 10617 of the H & S Code, relating to registration of previously unregistered births.
S.B. 308	221	Provides that health officer shall quarantine or isolate each case of tuberculosis.
S.B. 319	856	Provides for registration and examination of sanitarians employed in full-time State and local departments of health.
S.B. 375	663	To establish record of birth, death or marriage. Provides copy be sent by State registrar to the local registrar.
S.B. 432	1003	Amends an act entitled, "An act to provide for the creation, organization and government of water conservation districts."
S.B. 433	1004	Amends an act entitled, "An act to pro-

## COMMITTEE ON POSTGRADUATE ACTIVITIES†

### The Research Study Club of Los Angeles

*Fifteenth Annual Mid-Winter Postgraduate Clinical Assembly in Ophthalmology and Otolaryngology*  
January 21 to February 1, 1946

\* \* \*

*Special Courses in "Applied Anatomy and Cadaver Surgery of the Head and Neck"*  
February 1, 2, 3, 4 and 5

† † †

The American Board of Ophthalmology will conduct an examination in Los Angeles, January 16, 17, 18 and 19, 1946, immediately before our Mid-Winter Clinical Convention. (Those who wish to take this examination should apply promptly to the "American Board of Ophthalmology, Cape Cottage, Maine.")

The guest speakers for the 1946 Convention will include: For the *Eye*—Dr. Alan C. Woods and Dr. Jack S. Guyton, of Johns Hopkins Medical School, Baltimore, Maryland; Dr. Meyer Wiener, of Coronado, California; Frederick C. Cordes, of San Francisco, California, and Irving B. Lueck, B.S., of Rochester, N. Y. For the *Eye, Ear, Nose and Throat*—Dr. Herbert M. Evans, Berkeley, California, and Dr. William J. Kerr, of San Francisco, California. For the *Ear, Nose and Throat*—Dr. O. E. Van Alyea, of Chicago, Illinois; Dr. Richard Waldapfel, of Grand Junction, Colorado; Dr. Samuel Salinger, Chicago, Illinois; Dr. Samuel Fomon, of New York City, New York; Dr. Charles E. Kinney, Cleveland, Ohio, and Dr. Vern O. Knudsen, University of California, Los Angeles. . . .

#### *States the Program Committee:*

At our Convention in January, 1945, the large attendance caused some anxiety. In the Didactic Course an unlimited number can be accommodated; but it is clear that we must make some elaborate preparations for the Instruction Courses. From 31 states and Canada over 350 attended, and about 100 more would have been with us if it had not been for inability to secure either transportation from many parts of the country, or hotel accommodations in Los Angeles. Many have already arranged for their accommodations next year. Nearly one million extra people are in Los Angeles due to the war. It would be wise for those who plan to attend to make arrangements for accommodations *as soon as possible*. Should you prefer some hotel or apartment in Los Angeles, please write direct for reservations. Retain the reply from the hotel, in order that you may demand your rooms upon arrival here. If you have no choice of hotel, write to Mr. H. M. Nickerson, Manager, Elks Club, Douglas MacArthur Park, Los Angeles 5, and he will secure suitable reservations for you. Kindly advise Mr. Nickerson the approximate price you wish to pay for your rooms, thus enabling him to secure what you desire. . . .

In accord with requests from a majority of the members, the first week will be devoted to the Eye—from Sunday to Sunday. The Ear, Nose and Throat week will be from Friday to Friday—January 25 to February 1. Those of us who confine our work to only one of the specialties may complete either subject in one week. The Ear, Nose and Throat luncheon, on Friday, January 25,

is to be followed by an afternoon of didactic lectures and instruction courses. Saturday morning all subjects are to be of equal interest to both groups. It is probable that the Triologic Society, Western Section, will have its meetings on Saturday afternoon and Sunday morning. All members of the class are invited each year to the Triologic meetings. In brief, it is important for all members of the Ear, Nose and Throat group to be here on Friday morning, January 25.

The Round Table Luncheons, as in the past, will be the heart of the Convention. In general, the topics will be discussed along the line of the preceding lectures; in addition, all members of the Convention are urged to enter into an informal discussion on any live topics which deeply concern them. The members are also requested to turn in, in writing, subjects that they wish discussed, and the Committee will then select someone well fitted to open the discussion. (Lecturers should not be asked to discuss such questions with the individual. *Take them to the Round Table Luncheon so that all may benefit!*)

The *Special Course* in "Applied Anatomy and Cadaver Surgery of the Head and Neck" will be given directly after the Clinical Convention. Dr. Simon Jesberg, whose gifts as a teacher and clinician we already know, will conduct this Course in association with Dr. Samuel A. Crooks, Professor of Anatomy at Loma Linda College of Medical Evangelists. Dr. Crooks will demonstrate all anatomic relations in the different fields of head and neck surgery. As before, this course promises to be one of special practical value. The Cadaver Course will begin at the conclusion of the Clinical Course on February 1, 1946, and will continue into the following week—thus avoiding any conflict with the didactic lectures and the regular work of the Clinical Convention. Twenty cadavers are available. This Course is restricted to 40 members—two to each table. The fee is \$50.00. Naturally, the members will be enrolled in the order of registration. In the future, it may be possible to have a larger group, but it is probable that at present only 40 members can be included in the Cadaver Course.

The fee for the Clinical Convention is \$50.00; those in the Military Service are our guests. The fee for the Cadaver Course is \$50.00; those in the Service may enroll for one-half of the regular fee—namely, \$25.00.

### Wartime Graduate Medical Meetings

Note.—The C.M.A. Postgraduate Committee presents below the roster of speakers and topics of "Wartime Graduate Medical Meetings." These listings may have suggestive value to program committees of Component County Societies.

#### CLINICS, DEMONSTRATIONS, LECTURES

Under the Auspices of the American Medical Association, the American College of Physicians, the American College of Surgeons

Authorized by the Surgeons General,

Norman T. Kirk, Ross T. McIntire, Thomas Parran

#### *Committee 24th Zone*

Lt. Comdr. Geo. C. Griffith (MC), USNR, Chairman  
U. S. Naval Hospital, Corona

Capt. Harry P. Schenck (MC), USNR

Wayland A. Morrison, M.D.

James F. Churchill, M.D.

Program of the Wartime Graduate Medical meetings for Zone 24 (Southern California) follow:

#### *Birmingham General Hospital, Van Nuys*

Sept. 12—3:00 P.M.—"The Effects of High Altitude and Gravity," by Prof. D. R. Drury, University of Southern California.

Sept. 26—3:00 P.M.—"Cardiovascular Problems," by Dr. W. Gordon Garnett.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.



*Camp Cooke Station Hospital, Lompoc*

- Sept. 5—1:00 P.M.—"Respiratory Disease Problems," by Major F. E. Willett, M.C., AAF, USA.  
 Sept. 19—1:00 P.M.—"War Wounds of the Chest," by Lt. Comdr. J. P. O'Connor, MC, USNR, and Lt. Henry Jaffee, MC, USNR.

*Camp Haan, A.S.F. Regional Hospital*

- Sept. 4—3:30 P.M.—"The Pneumonias," by Dr. W. E. MacPherson, President, College of Medical Evangelists.  
 Sept. 18—3:30 P.M.—"The Use of Fibrin and Fibrinolysin in Wound Healing," by Capt. Harry P. Schenck, MC, USNR. (Joint meeting with March Field AAF Station Hospital, to be held at March Field, Riverside, California.)

*Hoff General Hospital, Santa Barbara*

- Sept. 5—8:00 P.M.—"Respiratory Disease Problems," by Major P. E. Willett, M.C., AAF, USA.  
 Sept. 19—8:00 P.M.—"War Wounds of the Chest," by Lt. Comdr. J. P. O'Connor, MC, USNR, and Lt. Henry Jaffee, MC, USNR.

*March Field, AAF Regional Station Hospital, Riverside*

- Sept. 18—3:30 P.M.—"The Use of Fibrin and Fibrinolysin in Wound Healing," by Capt. Harry R. Schenck, MC, USNR. (Joint meeting with Camp Haan ASF Regional Hospital, to be held at March Field.)

*Santa Ana Army Air Base Regional and Convalescent Hospital*

- Sept. 4—3:30 P.M.—"Acoustic Trauma," by Comdr. D. C. Mitchell.  
 Sept. 18—3:30 P.M.—"Rheumatic Heart Disease," by Dr. Louis E. Martin.

*Torney General Hospital, Palm Springs*

- Sept. 4—3:30 P.M.—"Surgery of the Biliary Tract," by Capt. Howard K. Gray, MC, Chief of Surgery, USA Naval Hospital, San Diego.  
 Sept. 18—3:30 P.M.—"The Management of the Simple Skin Diseases," by Lt. Col. Everett R. Seale, M.C., Chief of Dermatology, Santa Ana Army Air Base.

*U.S. Naval Hospital, Santa Margarita Ranch, Oceanside*

- Sept. 13—1:00 P.M.—"Cardiac Pain," by Lt. Comdr. Robert L. Langley, MC, USNR.  
 Sept. 27—1:00 P.M.—"Differentiation Between the Protozoal and Bacillary Dysenteries," by Dr. John F. Kessel, Prof. of Bacteriology, University of Southern California.

*U.S. Naval Air Training Station, San Diego*

- Sept. 7—3:00 P.M.—"Problems in Tuberculosis," by Comdr. W. L. Rogers, MC, USNR.  
 Sept. 21—3:00 P.M.—"The Malingering Tests," by Dr. John Mackenzie Brown and Mr. Raymond Brown.

*U. S. Naval Hospital, Long Beach*

- Sept. 19—3:00 P.M.—"Problems in Tuberculosis," by Comdr. W. L. Rogers, MC, USNR, Chief of Surgery, U. S. Naval Hospital, Corona.

*U. S. Naval Hospital, Corona*

- Sept. 13—1:00 P.M.—"Allergy," by Dr. John Lamson.  
 Sept. 27—1:00 P.M.—"The Rh Factor," by Capt. George Macer, M.C., USA.

*U. S. Naval Hospital, San Diego*

- Sept. 9—1:00 P.M.—"Clinical Aspects of Rheumatic Fever," by Lieut. Comdr. George C. Griffith, MC, USNR.

One day we will cast out the passion for Europe, by the passion for America.

—Emerson, *Conduct of Life: Considerations by the Way.*

## COMMITTEE ON ORGANIZATION AND MEMBERSHIP

### San Francisco County Medical Society Announces Appointment of an Executive Secretary— Frank J. Kihm

In the *Bulletin* of the San Francisco County Medical Society appeared the following:

"We are pleased to announce the appointment of Mr. Frank J. Kihm as executive secretary of the San Francisco County Medical Society. A long-felt want has grown into a critical need as the activities of the Society have increased and broadened its scope. In the crises now facing us and threatening the entire status of the practice of medicine, the consideration of public relations is vital and alone is sufficient to occupy the full time of a trained man. Even the routine management of the Society and its business at present exact more time and energy than practicing doctors can give. The full-time services of a man trained in organization and public relations can broaden the influence of our Medical Society and strengthen the position of the medical profession.

"Some months ago your Board of Directors approved the appointment of a full-time executive secretary, provided a suitable candidate for such a position could be found. Frank J. Kihm comes to us recommended and endorsed by John Hutton, executive secretary of the California Medical Association. He is a native American of American parentage and has been employed in San Francisco since 1922. Since August 1938, Mr. Kihm has been the city editor of the *Wall Street Journal*, Pacific Coast edition. Previous to this he has held executive positions in the business world involving advertising, writing and placing news releases, publicity, radio, magazine and newspaper work. November 6, 1942, he entered the United States Marine Corps as first lieutenant and on May 10, 1943, was promoted to a captaincy. His work in this branch of the armed forces was classification and assignment of enlisted personnel and classification of officers. He was released from active duty September 1, 1944, following satisfactory completion of his assignments and resumed his position as city editor of the *Wall Street Journal*.

"Mr. Kihm will assume his duties about September 15. We shall welcome the addition of his abilities to the working staff of the Society."

## COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

### Hospitalization Growth

A recent communication from the Hospital Service Plan Commission of the American Hospital Association, gives interesting information concerning hospitalization plans and statistics:

Records continue to be broken in the number of Americans joining voluntary non-profit plans for prepaying hospital bills. A total of 2,282,482 new members joined during the first six months' period of 1945 and thus exceeded by more than 500,000 the previous record membership growth established during the corresponding period of 1944.

This announcement was made recently by Dr. C. Rufus Rorem, director of the American Hospital Association's hospital service plan commission, who stated that the total Blue Cross membership in 43 states, the District of

Columbia, 7 Canadian provinces, and Puerto Rico now numbers 18,800,000 Americans.

Whereas a year ago, new members were enrolling nationally at the rate of approximately 12,000 per working day, the rate has now increased to almost 17,000 persons daily. More workers and family dependents joined Blue Cross during the first six months of 1945 than joined during the entire year of 1942.

Six states have passed the million membership mark. New York State leads with over 3,000,000 Blue Cross members; Ohio, 2,160,000; Pennsylvania, 1,933,000; Michigan, 1,303,000; Illinois, 1,222,000; and Massachusetts, 1,202,000.

A State-wide Blue Cross plan has just been approved for New Mexico which leaves only Arkansas, Mississippi, South Carolina, Idaho, and Wyoming without a community and hospital-sponsored plan for removing the financial worry of hospitalized illness or injury.

Doctor bill prepayment plans sponsored by state and county medical societies and made available to the public through coördination with Blue Cross hospital service plans increased in number from 19 to 24 during the first six months of 1945.

*Problems of Enrollment.*—Private insurance is usually sold by agents who canvass in the office, the factory, and the home. Experience shows that it does not sell itself. Consequently, commissions are offered to encourage the sale of insurance. But commissions are illegal for non-profit hospital and medical insurance in many states. Blue Cross protection is usually offered through salaried employees.

Enrollment expenses rarely exceed 3 per cent anywhere, and in some cases scarcely exist.

*Group Coverage Easiest.*—Most of the people in a community can usually be reached as groups of employees, which make up 95 per cent of the business of hospital service plans. Not only is it easier to get a large number of subscribers by the group method, but it has been found that plans are more apt to get the "average subscriber" by accepting many persons in a common office or employment at a time. The acceptance of a group protects the plan against "adverse selection," or too many poor risks. Group enrollment cuts down clerical work and bookkeeping expense, thus permitting a greater return in benefits for the subscriber's dollar. Most plans now accept groups as small as five—and even smaller units in rural districts. Group enrollment with payroll deduction is obviously the easiest and cheapest method of building membership. Where the employer will not provide collection facilities, it is often necessary to appoint one of the employees to make collections and look after the interests of the group. There are at least 100,000 of these group representatives, most of whom serve without pay. But if Blue Cross is to provide adequate security for the public, it must go beyond employed groups.

*Individual Membership.*—The Hospital Service Plan Commission has recommended broadening the base of Blue Cross membership. The Commission also urges plans to accept individuals who are self-employed or who for one reason or another cannot join a group. Some thirty plans have experimented with this type of subscriber, but as yet there is little individual enrollment anywhere except in some rural areas and in New York City, where there are over 75,000 non-group individual and family subscribers.

In New York, the experience in recent years with persons who cannot join through employed groups has been good. The practice has been to accept people on the basis of a medical questionnaire similar to that used by life insurance companies. Maternity benefits are usually given

only to group subscribers. Some of the plans will accept people without medical questionnaire during certain fixed periods, on the theory that most of the people who join during such a period will be in normal health. New York City, for example, is experimenting with a simple form of enrollment without medical questionnaire, during a limited period.

*Community Enrollment.*—One way of getting broader group coverage that has worked out particularly well is "community enrollment." A campaign is made to secure as members at least half the population of a village or town. This type of membership is not considered broad enough to be wholly desirable unless approximately 50 per cent join. In order to get such a large proportion, the aid of the mayor and local officials, local banks, the Grange, civic and health organizations women's clubs, and other associations is enlisted. Although insurance experts say that the best cross-section is obtained from employee groups, nevertheless lodges churches, societies of professional people, all of the doctors or dentists in a locality, all of the people residing upon a given street, or working in a large office building, may also be considered as a satisfactory group. Out of the many experiments now under way, the answer will be found as to the means of enrolling with a minimum of red tape, the self-employed, members of small establishments farmers, domestics, and others, many of whom are not now covered by Blue Cross or even by the old-age and survivors' insurance.

*Reaching the Farmer.*—It has always been hard for farmers to get satisfactory medical or hospital care. There are not nearly enough hospitals in rural areas, and farmers are independent and tend to avoid hospitals—especially when there are none nearby. Farms are widely scattered and the cost of collection and administration is therefore high. Living conditions on many farms are poor, and illness is more prevalent than in villages or cities. Yet farmers who lack money should be cared for just as well as the poor in cities.

Blue Cross is now making a serious effort to help country people get the hospital care they need. This is accomplished through cooperation with the Grange, the farm bureau, the union, the coöperative, the local bank, local mutual fire insurance companies, newspapers, creameries, and other marketing associations. More than twenty Blue Cross Plans are now actively trying to enroll families who live on farms and in villages. Even the poorer farmer is included. Hospital care has been made possible for many of those whom the Farm Security Administration aids in the purchase of the farm or equipment. The F.S.A. has helped by enrolling the farmers collecting the money, and turning it over to Blue Cross. This has made it easy for the individual farmer and for the Plan. The Farm Security Administration also attempts to provide medical care for its families through medical societies and medical plans. Altogether, Blue Cross farm enrollment approximates 500,000, and in addition, over 500,000 members of needy farm families are provided with medical care through the Farm Security Administration, Blue Cross, and medical prepayment plans.

### The Doctors' Plan of Medical and Hospital Care

Through the American Medical Association the physicians of the United States have offered a plan for voluntary "health insurance" which is quite comprehensive in scope and generally practical in its provisions. (Ed. Note. —See CALIFORNIA AND WESTERN MEDICINE for August, on pages 61-62, for A.M.A. and C.M.A. Principles.) The plan emphasizes local control and would limit the beneficiaries to those who helped pay the costs. In general it provides for medical care and hospitalization in



much the same manner used by private insurance companies and includes local care for indigents. Although suggesting Federal aid in some states if necessary, local administration and control would prevail.

The recent agitation about "health insurance" stems largely from a popular belief that medical and hospital costs are excessive and in many cases beyond the average pocketbook. Whether this belief is justified or not must be a matter of opinion. It is fitting, from this standpoint, that the medical profession should present some rational alternative to the various plans offered for compulsory insurance paid for by payroll taxes on employees and employers. Compulsory insurance, under either state or Federal auspices, not only would bring about regimentation of the people, but eventual regimentation and perhaps complete socialization of medicine. It is the part of wisdom for the country's physicians to meet the issue presented by some workable plan involving the minimum cost.

Most thoughtful and self-reliant citizens will prefer voluntary methods of providing for medical and hospital care, not only on the ground of individual freedom, but on the ground of equity. It is not consonant with justice for one group of citizens to be taxed for the special advantage of another group. Neither is state or Federal control desirable from a cost standpoint, as it is practically certain that such schemes as those already offered for compulsory insurance would result in heavy deficits to be made up out of the public treasury, thus invoking double taxation.

Already in existence are numerous private insurance companies offering medical and hospital benefits on a premium basis comparable to that proposed to be paid in payroll taxes. If the medical profession can work out some plan comparable with the plans of these companies—with even lower premium charges and larger benefits—it will perform a sound public service and remove a threat of socialized medicine which hangs over its head. —Editorial in *San Diego Union*.

## C.M.A. CANCER COMMISSION

### National Cancer Institute Act

In C. & W. M. for July, 1945, on page 33 reference was made to the National Cancer Institute Act. Additional information concerning some of its activities is given below.

#### *Traineeships in the Diagnosis and Treatment of Cancer*

In recognition of the need for more physicians specially trained in the diagnosis and treatment of cancer, Congress included in the National Cancer Institute Act a provision authorizing the Surgeon General—

To provide the necessary facilities where training and instruction may be given in all technical matters relating to diagnosis and treatment of cancer to such persons as in the opinion of the Surgeon General shall have proper technical training and shall be designated by him for such training or instruction.

The address of the National Cancer Institute is Bethesda, Md.

Ways and means of carrying out this section of the act were also taken up at the first meeting of the National Advisory Cancer Council, and Dr. James Ewing was appointed chairman of a group to study the question and make recommendations.

#### *Examination of Cancer Cures*

The Institute receives numerous letters from people who have, or who know someone who has, what they consider a "cancer cure." Most of these cures are formulas for a

paste or a salve which can be used only for treatment of external cancer. These correspondents are told that formulas of this kind have been known to the medical profession for many years but that since the discovery of x-ray and radium they have had only a limited use, therefore there is nothing to be gained by testing other formulas of the same or similar composition.

As to the examination of other types of treatment a definite policy approved by the National Advisory Cancer Council has been adopted. This policy provides that the applicant must meet the following requirements:

(1) The method of treatment must be explained fully. There must be no secrecy whatsoever in regard to the composition or the nature of the treatment.

(2) Complete clinical records must be submitted of a suitable number of cancer patients treated with the remedy or method in question under competent medical supervision, and in each case the diagnosis of cancer must rest on competent and verifiable microscopic examination.

### A.M.A. Council on Medical Service Appoints Advisory Committee to Coöperate with American Cancer Society

From the *Field Army News*, published by the American Cancer Society, July, 1945, the following excerpt should be of interest (for action taken by House of Delegates of California Medical Association at its annual session, held in Los Angeles, on May 6, 1945, see CALIFORNIA AND WESTERN MEDICINE, for June, 1945, on pages 324, 336 and 346):

The Council on Medical Service and Public Relations of the American Medical Association on May 11, 1945, took the following action as reported in the June 2 issue of the *Journal of the American Medical Association*:

American Cancer Society Clinics.—Mr. Louis Neff, Executive Director, American Cancer Society, discuss the program of the establishment of clinics by the society.

Dr. McCormick made the following motion after discussion: "The work of the American Cancer Society be supported by this Council with the understanding that all work done in the various counties be done under the supervision of the county medical society and that a committee be appointed by the chairman of this Council to act as an advisory committee of the Council coöperating with the American Cancer Society until such time as the committee on chronic diseases is appointed, when it might seem feasible for this committee to take over the work." The motion was seconded by Dr. McGoldrick.

At the same time, the Council appointed a committee "to act as an advisory committee of the Council coöperating with the American Cancer Society . . ." This committee consists of Dr. Thomas A. McGoldrick of Brooklyn, as chairman, Dr. Louis H. Bauer of Hempstead, New York, and Dr. Edward J. McCormick of Toledo, Ohio.

#### Policy

From the earliest beginnings of the American Cancer Society, it has held rigidly to the policy that all medical aspects of its program must be in the complete control of the medical profession. This policy was considered to be of utmost importance even when the activities of the Society were largely confined to educational efforts. It becomes of increased importance now that we are engaged in a program which includes a certain amount of service to the cancer patient.

The "Service" part of our program has developed from needs and conditions which have developed in the field, not from any organized effort on the part of the central headquarters. Transportation of patients to clinics, bandage or dressing projects, other forms of direct contact with the cancer patient, all have been the result of demonstrated local needs and have been organized and conducted under the supervision and direction of the local medical groups.

### New Commander of California Division of the American Cancer Society

Mrs. Stanhope Nixon, on August 6, was appointed State Commander of the California Division of the American Cancer Society.

Mrs. Nixon's appointment by the California Medical Association to the high post in cancer control work was announced by Mrs. Harold Bogert, southwestern regional director of the national society, here at present from her home in Denver, Colo.

Long a leader in civic and social affairs in Santa Barbara, her former home, and in San Francisco, Mrs. Nixon, since the war, has devoted most of her time to the American Women's Voluntary Services, which she organized in California and of which she is State president.

As State Commander of the American Cancer Society, she succeeds Mrs. Henry J. Ullmann of Santa Barbara.

### Marginalia

States the *Statistical Bulletin* of July, 1945:

Altogether, the recent trends in cancer mortality are encouraging, and there is reason to believe that real gains are being made. It is very likely that further progress will be achieved by advances in medical and surgical treatment and through discoveries in scientific research. But even in the present state of knowledge and medical practice, many thousands of lives could be saved annually by earlier diagnosis and treatment. Cancer control is a major challenge not only to the medical profession, but to the lay public as well.

THE AMERICAN CANCER SOCIETY  
350 Fifth Avenue, New York 1, N. Y.

August 15, 1945.

Dear Dr. Kress:

Because of a number of administrative changes due to the enlargement of the American Cancer Society's program, I am writing a rather belated letter on behalf of the directors of the American Cancer Society to express their appreciation for your help in contributing space during our campaign, through Mrs. Francis J. Rigney.

The contribution of space, amounting to many thousands of dollars, carrying the message "Guard those you love—Give to conquer cancer" aided us greatly and your continued help during these trying times, gives us all courage and inspiration.

Therefore, please accept our grateful thanks for all you have done for us in the past, and, we hope will continue to do in the future.

Sincerely yours,

AMERICAN CANCER SOCIETY.

## COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

### Better Health for the American People

Because undue concentration of authority limits freedom, restricts progress, and may lead to social injustice, proposals for government to become the dominant power in the American system of health care constitute a serious threat to the health welfare of the American people, the Michigan Health Council asserts in a newly published booklet of 12 pages.

The Michigan Council's statement points out that "democracy by its very nature forbids undue centralizing of authority." It urges thoughtful citizens to:

Examine every new plea of government aid, every proposal to delegate further authority to government.

Resist each such demand until it has been proven beyond question that the ultimate common good can best be served in no other way.

The booklet is published under the title "Better Health for the American People." It undertakes an analysis of the reasons why a democratic system of health care offers greater promise than any other system.

Five objectives for the attainment of better health care by democratic means are set forth in the booklet. They are:

1. Complete Health Prepayment Service for the Self Supporting.
2. Coöperation with Government to Furnish Health Care for Those Unable to Pay.
3. Improvement of Health Facilities and Standards.
4. Health Education of the Public.
5. National Coördination of Health Activities.

Copies of the booklet are available upon request to the Michigan Health Council, Washington Boulevard Building, Detroit 26, Michigan.

The Council was incorporated a year ago as a joint coördinating and educational organization of the Michigan State Medical Society, the Michigan Hospital Association, Michigan Medical Service and Michigan Hospital Service.

### "March of Dimes" of the National Foundation for Infantile Paralysis, Inc.

Topping last year's unprecedented donations by more than 50 per cent, the American people contributed \$16,589,874 to the 1945 March of Dimes of the National Foundation for Infantile Paralysis, as against \$10,973,491 for 1944, it was announced recently from the national headquarters at 120 Broadway, New York City. . . .

Of the total amount of funds raised, 50 per cent is allocated to national headquarters of the National Foundation to finance research into the cure and prevention of infantile paralysis and a broad educational program which includes scholarships and fellowships in orthopedic nursing, physical therapy, orthopedic surgery, virology and health education, as well as to maintain an emergency epidemic fund to aid County Chapters in areas hard hit by outbreaks of the disease.

The other half of the March of Dimes funds is retained by County Chapters of the National Foundation to carry on year-round services to infantile paralysis victims in the 3,070 counties of the United States.

The incidence of the disease this year is high, although there is marked improvement over last year when the United States had its second largest epidemic of infantile paralysis with a total of 19,272 cases. . . .

The total amount collected in California in the March of Dimes campaign was \$1,592,164.74, being exceeded only by New York, and followed by Pennsylvania.

### VD Allotments

A total of \$8,756,876 has been allotted by the Venereal Disease Division of the U. S. Public Health Service to the States and Territories for venereal disease control for the fiscal year ending June 30, 1946. Of the total, \$4,378,438 is to be matched by the States. This will assure a combined Federal and State venereal disease control budget of more than 13 million dollars for the year.

The allotment of Federal funds represents a national expenditure of 7 cents per capita for the control of venereal disease.

Allotments were made to the individual States on the basis of population, financial need, and the magnitude of



the general venereal disease problem in each State.

The allotments for California, and the amount of the allotments per capita follows:

	Allotment	Per Capita
California .....	\$409,036	\$.05

### Physician Statistics

Medical Mailing Service, Inc., in a recent circular, gave the following statistical information (approximate):

Active Practicing Physicians in the United States (All Ages) .....	108,809
Internes in the United States .....	5,583
Active Practicing Physicians Over 70 Yrs. of Age .....	14,966
Active Practicing Physicians Under 70 Yrs. of Age .....	93,823
Active Practicing General Practitioners (All Ages) .....	62,134
Active Practicing General Practitioners Under 70 Yrs. ....	51,491
Active Practicing General Practitioners Over 70 Yrs. ....	10,643

### Specialists

(Note. The requirements whereby a physician was construed to be a "specialist" were not given. However, the figures have a relative or suggestive interest.)

Allergists .....	252
A.L.R. (Ear, Nose and Throat) .....	1,460
Anesthetists .....	623
Bacteriologists .....	64
Cardiologists .....	432
Clinical Pathologists .....	306
Dermatologists .....	1,081
Gastroenterologists .....	237
Gynecologists .....	915
Industrial Practice .....	1,487
Internal Medicine .....	4,389
Neurologists .....	107
Neuro-Psychiatrists .....	1,208
Neurological Surgeons .....	85
O.A.L.R. (Eye, Ear, Nose and Throat) ...	3,970
Obstetricians .....	1,835
Obstetrician and Gynecologist .....	3,234
Ophthalmologists .....	1,572
Orthopedic Surgeons .....	989
Pathologists .....	612
Plastic Surgeons .....	82
Pediatricians .....	3,365
Proctologists .....	613
Psychiatrists .....	865
Public Health .....	1,272
Radiologists and Roentgenologists .....	1,804
Surgeons (General) .....	11,109
Tuberculosis .....	943
Urologists .....	1,764

Total Specialisis .....46,675

### Tests of the Effectiveness of DDT in Anopheline Control

An article on "Effectiveness of DDT in Anopheline Control" appears in *Public Health Reports*, issue of August 10, 1945, copy of which may be secured from the U. S. Superintendent of Documents, Washington (25), D. C. (Price, 10c). From this article by S. W. Simmons, Sanitarian, (R), and Staff, United States Public Health Service, the following excerpts:

The return of troops with malaria to anopheline-infested areas in this country creates an urgent need for improved methods of malaria control. This rapidly growing problem is superimposed on that of continued protection of troops in hyperendemic combat areas. In meeting these problems the use of the chemical commonly known as DDT (2,2-bis(parachlorophenyl) 1, 1, 1-trichloroethane) is indicated to be an improvement of the first magnitude.

Work was recently initiated at the Henry Rose Carter Memorial Laboratory in Savannah, Ga., to develop practical working information, procedures, materials and equipment for use on the Malaria Control in War Areas

program. Determination of the effectiveness and practicability of DDT in the control of anopheline mosquitoes is a major phase of work. At the outset, data previously secured by other workers was drawn on heavily as a foundation. Information secured from reports and personal conferences with workers from the Orlando, Fla., laboratory of the Bureau of Entomology and Plant Quarantine, the National Institute of Health, and various contractors with the Office of Scientific Research and Development has been particularly helpful.

The work on DDT in mosquito control has fallen into two principal categories: First, its use as a residual house spray, and secondly, its use as a larvicide. As a larvicide DDT is distinctly promising but results from its use as a residual spray are spectacular. No other material has been shown to impart lethal effects to sprayed surfaces over a period of time comparable to that obtained with DDT. It is this ability, when conjoined with established mosquito control practices, that has caused malariologists to conceive the practicability of malaria eradication. . . .

DDT is easily applied as a larvicide with existing equipment without appreciable modification, and the cost of materials is less than one-fifth that of fuel oil. Labor cost involved is approximately the same as for oiling.

It may be summarily stated that the work described is of a preliminary nature. A final definition on the toxic properties and use of DDT presents a striking challenge to all who are interested in malaria control.

### SUMMARY

The average tenant house can be treated with a DDT residual spray at a cost of about \$1.50 to \$1.75, including labor, materials, and overhead, but exclusive of initial outlay for heavy equipment. The spray can be applied either with a hand-pressure sprayer or with a power machine, and at a dosage of 200 mg. of DDT per square foot of surface area has effected a 60- to 90-per cent mortality of wild mosquitoes in unoccupied houses 20 weeks subsequent to treatment. A residual toxicity of this duration suggests that one treatment per year might be sufficient in the more northern malaria zones of this country, but two treatments will probably be required in the southern zones. . . .

### Safer to Land With Feet Close Together

Aside from enemy action, the statistical chance of a paratrooper being injured in a descent has been reduced to 1 per cent and is falling even lower than that.

The reduction in the number of parachute injuries was attributed largely to the teaching of new landing methods.

The old method of landing, it was explained, was with the feet approximately the width of the hips apart. In the new technique, the feet are held together on contact with the ground, with the leg bent slightly at the knees and the weight of the body slightly forward over the feet.

This has reduced considerably ankle fractures, which often used to plague parachutists.

*Fyodor Dostoevski (1821-1881).*—Within a minute of the order to fire, came work that the death sentence imposed on Dostoevski and the other revolutionists had been commuted to penal servitude in Siberia. This imprisonment, averred Dostoevski, cured his nervous disorders, but it also brought upon him the scourge of epilepsy. From birth to death, the life of this great novelist was one long succession of physical, social and spiritual misery. As a writer, Dostoevski made the field of morbid psychology his own.—Warner's *Calendar of Medical History*.

# MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

## NEWS

### Coming Meetings†

*California Medical Association.* Session will convene in Los Angeles. Dates of the seventy-fifth annual session, to be held in 1946, will be announced later.

*American Medical Association.* The 1946 Session is scheduled for San Francisco. Date not yet announced.

### The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in *CALIFORNIA AND WESTERN MEDICINE* for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576. Also, August, 1945, *CALIFORNIA AND WESTERN MEDICINE*, pp. 61-62.)

### Medical Broadcasts\*

*The Los Angeles County Medical Association:*

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a.m., under the title, "Your Doctor and You."

In September, KFAC will present these broadcasts on the following Saturdays: September 1, 8, 15, 22, and 29.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

For radio broadcasts of "Doctors at War" by the American Medical Association, see *J.A.M.A.*

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week. In *CALIFORNIA AND WESTERN MEDICINE*, some rosters appear in every second or third issue.

\* County societies giving medical broadcasts are requested to send information as soon as arranged.

### Pharmacological Items of Potential Interest to Clinicians\*

1. *On the Sociological Front:* Worth reading is L. Mumford's *City Development: Studies in Disintegration and Renewal*; maybe Honolulu should have followed Mumford's advice (Harcourt, Brace, N. Y., 248 pp., \$2, 1945). B. Malinowski analyses *The Dynamics of Culture Change* (Yale Press, New Haven, 171 pp., \$2.50, 1945). Laura Thompson and Alice Joseph discuss *The Hopi Way* (to peace), and note high IQ of Hopi children (University Chicago Press, 151 pp., \$3, 1945). D. Abrahamsen dilates on *Crime and the Human Mind* (Columbia University Press, N. Y., 244 pp., \$3, 1944). Do you know the Social Work Year Books? 8th issue, 1945, edited by R. H. Kurtz, 620 pp., at \$3.25, from Russell Sage Foundation, N. Y. Along the usual line is O. S. English and G. H. J. Pearson's *Emotional Problems of Living: Avoiding the Neurotic Pattern* (Norton, N. Y., 438 pp., \$5, 1945). M. F. A. Montagu concludes that intelligence tests at last war show correlation with socioeconomic history (*Amer. J. Psych.*, 58:161, 1945). J. N. Morris examines health of 440 millions in India, in light of population crisis, and sees little hope (*Lancet*, 1:743, June 16, 1945). V. Bush looks at tomorrow, bravely speculating on how we may think mechanically with logic machines (*Atlantic*, 176:101, July, 1945). And what is your idea of Federal subsidy for scientific work? C. Binger gives excellent and brief popularization of *The Doctor's Job* (Norton, N. Y., \$3.50, 1945).

2. *On Cells and Tissues:* R. Hober offers important *Physical Chemistry of Cells and Tissues* (Blakiston, Philadelphia 5, \$9, 1945). Volume 5 of *Advances in Enzymology and Related Subjects* is edited by F. F. Nord and C. H. Werkman (Interscience Publ., N. Y., 268 pp., \$5.50, 1945). E. Schrodinger also asks *What Is Life?* (Macmillan, N. Y., 91 pp., \$1.75, 1945). R. A. Moore edits Volume 11 of *Biological Symposia on Ageing and Degenerative Diseases* (Cattell Press, Lancaster, Pa., 242 pp., \$3, 1945). R. A. Moore also offers new text on Pathology (W. B. Saunders, Philadelphia 5, 1338 pp., \$10, 1945).

3. *On Antibiotics:* L. F. Moldavsky & Co. of Harmon Gen. Hosp. warn against danger of thrombus formation with high doses of penicillin and suggest its use as a coagulant in hemorrhagic diseases (*Science*, 102:38, July 13, 1945). L. Loewe & Co. report plasma conc. of p-aminohippuric acid of 10 mgm./100 cc. (non-toxic) greatly prolongs penicillin action (*Proc. Soc. Exper. Biol. Med.*, 58, 298, 1945). J. T. Weld notes antibiotic action of extracts of *Tillandsia usneoides* (Spanish moss) (*Ibid.*, 59:40, 1945). J. A. Herrick observes fungicidal action of clavacin (*Ibid.*, p. 41). D. Jones & Co. find evidence for antiviral action of actinomycin A (*Science*, 101:665, June 29, 1945). D. Perlstein & Co. propose urinary estimation of glucuronic acid as measure of penicillin absorption (*Science*, 101:562, June 1, 1945). W. F. Elias and J. Durso note little absorption of streptomycin from gut and possible presence of body inhibitor (*Ibid.*, p. 589, June 8, 1945). S. Waksman proposes excellent method for standardization of streptomycin (*Science*, 102:40, July 13, 1945). W. M. M. Kirby

\* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacological Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.



describes properties of penicillin inactivator from penicillin resistant Staph. (*J. Clin. Invest.*, 24:165-175, 1945).

4. *On Hormones*: Just noted is comprehensive discussion of synthetic hormones by G. Masson (*Rev. Canad. Biol.*, 3:491-582, 1944). J. P. Chu and S. S. You (Chengtu), offer evidence that follicle stimulating and luteinizing hormones of pituitary are under direct regulation of thyroid (*J. Endocrin.*, 4:115, 1945). J. E. Caldwell & Co. find specific agent in bone marrow able to stimulate leucopoiesis in benzene poisoned rabbits (*Am. J. Med. Sci.*, 209:717, 1945). I. J. Kligler & Co. observe that environmental change from dry to humid with constant temperature activates thyroid, explaining our pep at Galveston (*Proc. Soc. Exper. Biol. Med.*, 58:286, 1945).

5. *On Varia*: E. A. Stead, Jr. & Co., report neat studies on cardiac output (*J. Clin. Invest.*, 24:326-344, 1945). A. M. Martinex offers full survey of leucocyte variations in pulmonary Tb (*Publ. Cent. Invest. Tisiol.*, 8:281-420, 1945). C. Torda and H. G. Wolff claim muscle fatigue may be result of decrease in local synthesis of acetyl-choline during prolonged muscle contractions (*Proc. Soc. Exper. Biol. Med.*, 59:13, 1945). P. A. Neal and Co. report fully on low toxicity and potential danger of aerosols containing DDT (Supplements No. 177 and 183 to *Pub. Health Rep.*, Washington, 1945). J. M. Schneck offers interesting bibliography on bibliography (Psychiatrists, please note!) and hospital libraries (*Bull. Med. Lib. Assoc.*, 33:341, 1945). G. King and L. T. Ride correlate thiamine deficiency with pregnancy toxemia (*J. Obs. Gyn. Brit. Emp.*, 52:130, 1945). C. P. G. Wakeley skillfully analyses effects of underwater explosions on human body (*Lancet*, 1:715, June 9, 1945).

**Baruch Committee on Physical Medicine.**—The Baruch Committee on Physical Medicine, established in 1944 by Mr. Bernard M. Baruch of New York, with a gift of \$1,190,000, is achieving results beyond its most hopeful expectations. This is made clear in its first annual report.

In creating the committee and bestowing his benefaction in April, 1944, Mr. Baruch announced that its purpose would be to advance and encourage the knowledge and practice of physical medicine throughout the nation and the world—with the special aim of bringing its benefits to disabled veterans of the war, and assisting in their rehabilitation and restoration to working health and usefulness.

The committee states: Physical medicine is that branch of medical science which, in conjunction with or succeeding surgery and hospitalization, undertakes the long course of restoration to working activity by the employment of heat, light, water, electricity, massage, manipulation, exercise and mechanical devices. It is a field brought into prominence and importance by the last war and rendered immeasurably important by the present one both to the medical profession and mankind. The field, previously, had been imperfectly understood and much neglected.

The medical schools of ten universities and colleges—their chain extending clear across the United States—are participating in the original gift of \$1,190,000 by Mr. Baruch, and the report lists the various activities and achievements which have been made possible to them by its bestowal.

In the list of grants to different institutions, the University of Southern California becomes the recipient of an allocation of \$30,000.

The chairman of the Baruch Committee on Physical Medicine is Doctor Ray Lyman Wilbur, Chancellor of Stanford University.

**Medical Bill.**—With the nation's medical bill in 1944 totaling 4 billion dollars and a capital investment in hospital plant and equipment of six billions, medicine today is one of the big businesses of America. The direct consumers of medical care paid 3 billions of last year's bill, expenditures by federal, state and local governments were 800 millions, and the balance was contributed by industry and philanthropy, a survey revealed.

**Scholarships for Physical Education Courses.**—In a recent announcement, the National Foundation for Infantile Paralysis, with headquarters at 120 Broadway, New York 5, states that it has allocated an appropriation of \$1,267,600 by the National Foundation which makes it possible to offer scholarships to young men and women who have been graduated from accredited schools of nursing or physical education, or who have completed a minimum of two years of college work with emphasis on biology and other basic sciences. Candidates with the proper prerequisites will be trained at physical therapy schools approved by the Council on Medical Education and Hospitals of the American Medical Association.

This program was developed with the advice of a special committee composed of Dr. Irvin A. Abell, of Louisville, Ky., chairman, and Dr. Donald B. Armstrong, of New York; Dr. Max M. Peet, of Ann Arbor, Mich.; Dr. Morris Fishbein, of Chicago; Dr. Arthur L. Watkins, of Boston; Dr. M. G. Westmoreland of Chicago; Miss Jessie Stevenson, of New York, president of the American Physiotherapy Association; Miss Lucille Daniels, acting director of the division of physical therapy, Stanford University, Calif.; Dr. Don W. Gudakunst, medical director of the National Foundation; Miss Catherine Worthingham, director of technical education for the Foundation, and Basil O'Connor.

The committee feels that the lack of qualified physical therapists today has hindered physicians from making a wider use of physical therapy in various medical specialties.

**Recent Mortality Rates for United States.**—The general death rate for the United States for the first quarter of 1945, as estimated from a 10 per cent mortality sample, is 11.3 per 1,000 population. This is 7 per cent lower than the corresponding rate of 12.1 for the same months of 1944.

In comparing the mortality experience for the first quarter of 1945 with that for the first quarter of 1944, it should be pointed out that death rates for the respiratory diseases and consequently the general death rate are subject to considerable variation. In the 11-year period 1933 to 1943 the general death rate for the United States varied from a maximum of 13.3 in 1937 to a minimum of 11.3 in 1942. Thus, it will be seen that the base with which comparison is made is somewhat high and that the first quarter rate for 1945 compares favorably, not only with that for the preceding year, but also with the low rate for the corresponding period of 1942.

The more favorable mortality record for the first quarter of this year over that for last year comes principally from lower death rates for pneumonia and influenza and the cardiovascular-renal group of diseases. Last year there was an increased mortality from these causes as a result of an epidemic of upper respiratory infections. The pneumonia and influenza death rate for the current quarter (37.7 per 100,000 population) is only about three-fifths as high as that for the first 3 months of 1944, and is lower than in any previous first quarter. The death rate for the cardiovascular-renal group of diseases accounted for about half of the total deaths was 5 per cent lower in the first quarter of this year than in the

same period last year, and was approximately the same as the first quarter of 1943.

**Information for Disabled Veterans.**—The "Public Affairs Committee," 30 Rockefeller Plaza, New York 20, is a non-profit educational organization that has brought out many interesting pamphlets. A recent brochure has the title, "Straight Talk for Disabled Veterans." The authors describe a number of actual instances out of tens of thousands that could be cited to prove that men bearing all kinds of physical losses can achieve economic independence and build for themselves lives that are as satisfying and happy as anyone's. They point out that one company alone employs nearly 12,000 disabled men on regular jobs. They tell of cases in which men earned more after being disabled than before their injury.

Disabled men are warned, however, that success does not come without great effort. They are urged to co-operate with their physicians and nurses in activities designed to overcome the effects of their injuries, and to get the best training possible for their future jobs.

By law the disabled veteran is guaranteed an opportunity to prepare for work in which he will not find himself at an economic disadvantage. But the veterans are warned that the law is not going to be of much help unless they take some responsibility for discovering and training for the kind of work they are capable of doing.

**University of California Plans Continuation Courses for Dentists.**—Continuation courses in dentistry for dental officers returning from the armed services or for dentists who wish to review the latest phases of dentistry are being planned by the College of Dentistry, on the San Francisco campus of the University of California.

Sixteen types of classes are being scheduled, including two to six weeks' intensive instruction in the handling of certain difficult problems, and others to continue for one or more semesters will prepare for advanced specialties such as orthodontics or prosthesis. Graduate studies will be offered for those students who wish to specialize in dental medicine or build up a biological background for research and teaching.

Dr. Gordon Fitzgerald, head of the division of dental roentgenology, is in charge of the program. There is an excellent opportunity for returning dental officers to study for dental specialties, since they will not have established practices to leave or office overhead to worry about.

**Bulletins of the Health Advisory Council of the Chamber of Commerce of the United States.**—The Washington, D. C., office of the Chamber of Commerce of the United States of America, through its "Health Advisory Council," from time to time sends to the newspaper and magazines, releases dealing with health and disease problems. The value of this educational work is hard to estimate. Excerpts from their Bulletins follow:

*Health Education Sponsored by Doctors Reduces Appendicitis Deaths by Two Thirds.*—Deaths of patients with acute appendicitis in one state decreased from 3.39 per cent to 1.1 per cent in five years as a result of preventive medicine and surgery and increased public knowledge.

The latest report of the Pennsylvania State Medical Society's Commission on Acute Appendicitis Mortality shows that public health education stimulated by doctors, and aided by schools, civic organizations, and other lay groups, saves lives.

In Pennsylvania, where the State Medical Society has been very active in educating the public regarding appen-

dititis, the number of deaths from appendicitis-peritonitis has been reduced from 1,252 in 1930, to 886 in 1940, and 624 in 1942.

The commission's report shows that delay in seeking medical attention or in going to a hospital, and the taking of laxatives are the all-important controllable factors in deaths from acute appendicitis. The danger to acute appendicitis patients from taking laxatives more than doubled from 1937 to 1942, the Pennsylvania study revealed, as is shown in the following table:

1937		1942
1 in 6 died	No laxative taken	1 in 3 died
1 in 4 died	One laxative taken	1 in 2 died
1 in 4 died	More than one laxative taken	2 in 3 died

Good advice regarding appendicitis is contained on stickers which Pennsylvania doctors are using as seals on letters, and distributing through schools, as follows:

#### APPENDICITIS—PLAY SAFE!

##### THAT PAIN IN YOUR STOMACH MAY MEAN

1. Take NO laxatives, liquids or food.
2. See your DOCTOR at once.
3. Go to the hospital if he advises operation.

REMEMBER—laxatives and delay cause spreading peritonitis and death—1 in every 3 cases.

PLAY SAFE WITH YOUR OWN LIFE—DON'T DELAY!

(Signed) Medical Society of the State of Pennsylvania.

*Polio Precautions:* August and September are the months during which the yearly peak of poliomyelitis, or infantile paralysis, cases occurs in most localities, and during which it is advisable to keep in mind precautions that help prevent spread of the disease.

The most important fact to remember about infantile paralysis is to call a doctor promptly for anyone who has any of its symptoms. These include moderate fever, headache, vomiting and constipation, drowsiness alternating with irritability, stiffness of neck and spine, trembling and other signs which a doctor can detect better than a patient.

Although the chances of an individual acquiring infantile paralysis are ordinarily only about 1 in 10,000 during a year, and only 1 in several hundred even during an epidemic, precautions are advisable when poliomyelitis is prevalent.

Important poliomyelitis control measures include:

Early diagnosis and reporting of the disease; isolation of infected persons for two weeks from onset; immediate disinfection of all nose, throat, or other bodily discharges of infected persons, and of articles soiled by such discharges; search for and expert diagnosis of sick children to locate unrecognized and unreported cases.

During epidemics all children with fever should be isolated in bed until they have been examined by a doctor; bed rest is particularly important for persons found to have the disease. Children should be protected as much as possible against unnecessary contact with persons outside their own homes during epidemics. Unnecessary travel, physical strain, and nose and throat operations should be avoided when the prevalence of poliomyelitis is high.

*On the meaning of "Psychosomatic Medicine":* One of the newest phrases in your doctor's vocabulary is "psychosomatic medicine," and you should know what it means to understand an interesting and important new strategy developed by physicians in their fight against ill health.

In everyday language, "psychosomatic" means "mind-body." "Psychosomatic Medicine" is concerned with the way emotional and physical disturbances influence each



other, particularly with bodily disorders which are brought on, made worse, or prolonged by emotional disturbances.

Physical illnesses which doctors have found to be frequently caused by or associated with disturbed emotions include gastric ulcer, constipation, some skin diseases, headaches, asthma, high blood pressure, various heart diseases, rheumatic fever and rheumatic heart disease, diabetes, and even broken bones.

Physicians tell us that very often the patient is not consciously aware of the emotional disturbance that is causing his heart or stomach trouble, or some other physical disorder; the original cause of the upset emotions may have occurred years previous to the physical illness.

Jealousy, repressed fear or rage, resentment, and guilt are some of the emotions which may affect the nervous system and, in turn, the organs or tissues of the body in such a way as to bring on physical illness that prescriptions or surgery alone cannot cure.

**California Heart Association Meetings.**—The Annual Postgraduate Symposia on Heart Disease held under the auspices of the California Heart Association will be given as follows:

In *San Francisco*, on October 17, 18, 19 and 20 (Wednesday through Saturday). Physicians may register with the San Francisco Heart Committee, 604 Mission Street, San Francisco, 5, Mrs. Gladys Daniloff, Secretary.

In *San Diego*, on October 22nd (Monday). Symposium is sponsored by the San Diego County Medical Society. (Dinner meeting place to be announced later.)

In *Los Angeles*, on October 24, 25, and 26 (Wednesday through Friday). Physicians may register with the Los Angeles Heart Association, 117 West 9th Street, Los Angeles, 15, Mrs. Ruth Lynch, Executive Secretary.

Among the guest speakers will be Dr. Samuel A. Levine of Boston, Colonel Irving S. Wright, U. S. Army Medical Corps, Dr. James J. Waring, Professor of Medicine, University of Colorado School of Medicine.

**What G. I.'s Want When They Return.**—While Drew Pearson was on vacation Sgt. Max Novack, who writes "What's Your Problem?" for *Yank*, the Army weekly, contributed a guest column on the returning soldier. The following excerpts are from "Washington Merry-Go-Round" in *San Francisco Chronicle*, August 27):

... The chief thing that the man in uniform wants is to return to civilian ways of life. No one who has not had to forego the right of individual action for from two to four years can possibly understand the importance of being able to make his own decisions.

... However, many G.I.s realize that merely providing free schooling, Government-guaranteed loans and unemployment protection does not mean that all their problems will be solved by the G.I. Bill of Rights.

... Many of the G.I.s also want compulsory high school education for all, slum clearance, low-cost housing projects and universal or group hospital and medical care. If these come into being, they feel that the better world they have heard so much about will actually come about in their and their children's time. . . .

**U. S. Population Estimated 139,682,000.**—A population increase of more than eight million was registered during the five years ended July 1, almost equal to the 8,894,000 increase in the 10 years ended in 1940, the Department of Commerce has announced.

The population on July 1, 1945, was estimated at 139,682,000.

In the 3½ years ended July 1, births totaled 10,569,000.

This was more than double the 5,137,000 deaths, not counting war casualties.

The marriage rate reached a new height at 13.5 per 1,000 of population as of 1942. In the 3½ years ended July 1, 1945, marriages totaled 5,477,000.

Peak employment, reached in July, 1943, was nearly 55 million. In late 1944, factory employment was 17,250,000, about double that of 1939.

Female employment increased more than seven million in the five years between 1940 and 1945, to 18,200,000.

Unemployment in July, 1944, had hit a new low of one million, or less than 2 per cent of the labor force. This compared with an unemployment ratio of 15 per cent of the total labor force or 8,410,000 in July, 1940.

## MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.

*San Francisco*

### Birth Certificates

*California Health and Safety Code*, Section 10150, provides that the birth of each child born in the State of California must be registered pursuant to statute. Except in sparsely settled districts, or where there is no direct mail communication with the County Seat, a certificate of birth must be filed within four days after the date of each birth with the local Registrar of the district in which the birth occurred.

If a physician was in attendance upon the birth, the duty of filing the certificate is imposed, by Section 10178 of the Health and Safety Code, upon the physician. Section 10180 also provides that the father or mother of the child, the householder or owner of the premises where the birth occurred, or the manager or superintendent of the public or private institution where the birth occurred, each in the order named, shall, within ten days after the date of the birth, report the fact of birth to the local Registrar. Under Section 10180, any information which the physician is unable to fill in on the form of birth certificate prescribed by the statute, must be obtained by the local Registrar from the person reporting the birth. There is, then, a double requirement imposed by the Vital Statistics statute, viz.: (1) That the attending physician file a birth certificate; and (2) That one of the other persons named in Section 10180 report the birth. The form of birth certificate prescribed by Section 10200 of the Health and Safety Code requires that the attending physician sign a certificate as to his attendance at birth, including a statement of the hour of birth.

We have found no cases in California interpreting Section 10178, the section which requires the attending physician to file a birth certificate, and no case in which the validity of this section has been questioned. It has been held in other states, however, that the state may, in the exercise of its police power, lawfully require a physician to report to the proper authority for registration of the fact of a birth which has come under his or her observation. *Robinson v. Hamilton* 60 Iowa 134, 25 Am. Jur. 320.

A decision of the Ohio Supreme Court, *State v. Boone*, 84 Ohio 346, is summarized in Volume 25 Am. Jur. at page 320, as follows:

"But a statute requiring an investigation and notification as to facts not necessarily or naturally coming

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

within the knowledge of the attending physician or midwife—namely, whether the birth is legitimate or illegitimate—and, except in case of illegitimacy, the full name, residence, color or race, birthplace, age and occupation of the father, also the maiden name in full, residence, color or race, birthplace, age, and occupation of the mother, the number of this child of the mother, and the number of her living children, has been held to be unconstitutional as requiring the physician or midwife to search out non-professional information without compensation, and as being not a valid exercise of the police power because unnecessary, unreasonable, and arbitrary."

And it is further stated:

"Some courts, however, have taken the view that a statute requiring on birth or death certificates information not within the personal knowledge of the physician is a valid exercise of the legislative discretion, but that the physician is required thereunder only to make a bona fide effort to secure the information, and that having done so, he is not liable for a penalty."

The California statute gives no indication as to who is a "physician" within the meaning of the section requiring the attending physician to file a birth certificate. In Maryland it has been held that a duly licensed and registered osteopath is to be considered a physician within the meaning of the Vital Statistics statute, unless the statute expressly precludes the acceptance of a certificate signed by an osteopath.

The California Vital Statistics statutes impose an additional requirement on attending physicians in the case of still-born children. In the case of a still-born child who has advanced to the fifth month of uterogestation, a certificate of still-birth must be filed with the local Registrar, just as in the case of a death certificate. Health and Safety Code, Section 10328 provides that the medical certificate of still-birth shall be signed by the attending physician and shall state the cause of the still-birth, if known.

## LETTERS†

### Concerning "A Central Medical Registry":

(COPY)

THE AMERICAN REGISTRY OF PATHOLOGY  
Under the Auspices of National Research Council  
Registry Office: Army Medical Museum  
Washington 25, D. C.  
Washington, D. C., July 30, 1945.

To the Editor:—We wish to express hearty agreement with the ideas advanced by Dr. Askey in your June number, on page 317, concerning the need for a central medical registry.

The Army Institute of Pathology, under the aegis of the National Research Council and various national medical societies, for some time has been maintaining 13 Registries, the first of which was founded by Colonel George R. Callender in 1922. Material is received from pathologists throughout this country and overseas, and one of the Registries (Bladder Tumor) now includes specimens from nearly 5,000 patients, who have been followed up yearly. These data will soon be ready for exhaustive and definitive analysis. It is only by pooling experience and material that accurate basis for making prognoses can be established and the natural history of diseases studied. We should like to impress on readers of your JOURNAL that material relevant to the Registry fields (General Tumor, Dermal, Lymphatic, Ophthalmic, Otolaryngological, Bladder, Kidney, Prostate, Chest, Dental and Oral, Neuropathologic, Orthopedic, Veterinary and Gerontologic) should be forwarded to the Institute.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Representative examples of the specimens entered in each Registry have been used to prepare Study Sets and Atlases, which are in constant use by physicians preparing for specialty Board examination or reviewing fields of particular interest. These materials may be borrowed on application to the Institute Director, Army Institute of Pathology, Army Medical Museum, Washington 25, D. C.

(Signed) J. E. ASH,  
Colonel, Medical Corps,  
Director.

### Concerning Taxation of X-Ray Films or Negatives:

For reference to the exact wording of the California Board of Equalization's revised ruling, a copy of the Board's letter of June 11, 1945, is printed below. (For reference in this issue of C. and W. M., see page 135.)

(COPY)

STATE BOARD OF EQUALIZATION  
STATE OF CALIFORNIA  
Sales Tax Division

Sacramento 14, June 11, 1945.

Peart, Baraty & Hassard,  
111 Sutter Street,  
San Francisco 4, California.

Attention: Mr. Hartley F. Peart.

Gentlemen:

This is with reference to our previous correspondence regarding the application of Sales and Use Tax Ruling 23, Subdivision C, as amended April 1, 1945, to x-ray laboratories operated by radiologists.

We have advised our staff that the tax applies to the fair retail value of x-ray pictures or negatives only when there is an actual sale, i.e., transfer of title, by the producer thereof. If the producer retains ownership of the pictures or negatives, he is the consumer of film and other materials used in their production, and the tax is therefore applicable with respect to the sale of such materials to him.

We believe that the foregoing will clarify many of the problems that are currently arising with respect to the application of the ruling.

Very truly yours,  
(Signed) E. H. STETSON,  
Associate Tax Counsel.

### Concerning "Bulletin" of Alameda County Medical Association:

(COPY)

ALAMEDA COUNTY MEDICAL ASSOCIATION  
364 Fourteenth Street, Oakland 12, California  
Oakland, August 14, 1945.

George H. Kress, M.D., Editor, Addressed.

Dear Doctor Kress:

Thanks for your generous remarks regarding our first issue of "The Bulletin" of the Alameda County Medical Association.

These have been received from all parts of the Nation. . .

Seriously, however, we realize that there are a number of things regarding "The Bulletin" that need very much to be improved, and shall look forward to timely criticism, bouquets, or brickbats whenever they are desired.

Cordially yours,

ALAMEDA COUNTY MEDICAL ASSOCIATION,  
Milton H. Shutes, Editor,  
(Signed) ROLLEN W. WATERSON,  
Executive Secretary.



### Concerning Numbers of Valid Signatures Needed for an Initiative Law:

(COPY)

STATE OF CALIFORNIA  
Office of the Secretary of State  
Sacramento, 3

Sacramento, August 2, 1945.

George H. Kress, M.D., Secretary,  
San Francisco.

Dear Doctor:

In reply to your letter of August 1, we advise that the number of signatures necessary to place an initiative upon a ballot at the present time is 178,764.

Yours very truly,

(Signed) FRANK M. JORDAN,  
Secretary of State.

### Concerning Examinations by American Board of Ophthalmology:

AMERICAN BOARD OF OPHTHALMOLOGY

To the Editor.—Due to transportation difficulties the examination of the Board, originally scheduled for Chicago, October, 1945, has been postponed to January 18th to 22nd inclusive, 1946.

Examinations in 1946, will be held in Chicago, January 18th, through 22nd; Los Angeles, January 28th, through February 1st; New York, May or June; Chicago, October.

### Concerning Need of Physicians for Posts in China:

UNITED NATIONS

RELIEF AND REHABILITATION ADMINISTRATION

August 31, 1945.

To the Editor:

May I ask you to be good enough to help us by bringing the following to the notice of the members of your Association?

The Chinese Government has requested UNRRA to provide, as soon as possible, some 200 field personnel of the following categories to strengthen the available Chinese personnel. Such personnel will be required to head the respective services in hospitals of 100 or 250 beds, which will be established in areas recently liberated from the Japanese.

General Surgeons  
Orthopedic Surgeons  
Genito-Urinary Surgeons  
Gynecologists and Obstetricians  
General Physicians  
Dermatologists and Syphilologists  
Ophthalmologists  
Otolaryngologists  
Radiologists  
Dentist  
Pediatricians  
Laboratory Technicians  
X-ray Technicians  
Sanitary Engineers  
Public Health Engineers  
Public Health Nurses  
Clinical Nurses

General practitioners with some specialist experience will be acceptable. Candidates should be under 55 years of age and in good physical condition.

Will those interested please write to me at UNRRA, 1344 Connecticut Avenue, N.W., Washington 25, D. C.

Yours sincerely,

(Signed) SZEMING SZE, M.D.,  
Chief, Far East Section,  
Health Division.

### Outpatient Penicillin Therapy of Sulfonamide Resistant Gonorrhea

Under the above caption, from the Venereal Disease Clinic, Christian County Health Department, Hopkinsville, Ky., William F. Fidler, Passed Assistant Surgeon (R), United States Public Health Service, writes as follows in the *Journal of Venereal Disease Information* of the United States Public Health Service for July, 1945:

The efficacy of penicillin in the treatment of gonorrhea was established early in the clinical study of the drug. However, treatment schedules covered relatively long periods of time, the drug being given at either 3- or 4-hour intervals, or by continuous intravenous drip. In April, 1944, Cohn, Studdiford, and Grunstein published studies on the relatively rapid treatment of gonorrhea in females. The treatment period ranged from 3 to 12 hours, injections being given at 3-hour intervals with a total dosage of 50,000 to 100,000 units. A failure was observed in 1 patient who received 50,000 units administered in 3 hours. The Army has been using a schedule of 100,000 units given over a 12-hour period with a 3-hour interval between doses. . . .

#### SUMMARY

1. From the experience of other investigators, it would seem that a greatly shortened penicillin treatment schedule for gonorrhea is effective.
2. A 4-hour schedule, consisting of a total of 100,000 units of penicillin given in 3 doses of 33,333 units each at 2-hour intervals, was instituted for patients with sulfonamide resistant gonorrhea.
3. Complications were seen in 13 of the 54 patients treated.
4. The patients varied widely as to age: 16 were male and 38 female; 27 were white and 27 Negro.
5. Of the 42 cases followed, 95 per cent satisfied the established criterion of cure, 3 consecutive negative cultures over a minimum of 21 days after the first treatment.
6. The 2 failures were cured by retreatment, giving a rate of cure of 100 per cent.
7. All complications cleared up rapidly.
8. Neither previous treatment nor duration of infection seemed to affect the results.
9. There was no evidence of toxicity in any patient.
10. Our experience indicates that a shortened schedule for the penicillin therapy of gonorrhea in outpatients is effective.

### Sir Alexander Fleming—Discoverer of Penicillin

Dour, white-thatched Sir Alexander Fleming, discoverer of penicillin, is fearful of the consequences of uncontrolled distribution of his "baby." In a recent interview Sir Alexander remarked that there was danger of "educating the microbe to resist penicillin." In his talk at a dinner tendered him by penicillin producers and the following evening he again referred to this fear. "The greatest possibility of evil in self-medication is the use of too small doses so that instead of clearing up the infection, the microbes are educated to resist penicillin and a host of penicillin-fast organisms is bred out." But he went on to express the hope that this danger could be averted.

The grave-eyed, modest hero of healing described some early difficulties in isolating and identifying *Penicillium notatum* mold after the chance discovery of its powers. He recalled that the original strain of *Penicillium notatum* was isolated by a Swedish pharmacist named Westling, from decaying hyssop. The earliest reference to penicillin might be the portion of Psalm 51 that says, "Purge me with hyssop that I shall be cleansed."

Dr. Coghill, of the Northeastern Research Laboratories in Peoria, once described the search for the best-producing strain of *Penicillium notatum*. Among other things, Air Forces pilots were requested to bring back samples of mold from the "four corners of the earth," but in the end, the highest yield of penicillin was found on a moldy cantaloupe rescued from a Peoria backyard!

## TWENTY-FIVE YEARS AGO†

### EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 9, September, 1920

EXCERPTS FROM EDITORIAL NOTES

*Vote No on Number 5 the Chiropractic Initiative.*—Certain groups of Chiropractors apparently believe that California can only be won by violence and that the violent will bear away the palm. The campaign for this purpose was outlined in "Fountain News," page 4, Number 34-35, published by the Palmer School of Chiropractic, Davenport, Iowa. . . .

The proposed Chiropractic Initiative Measure which will be presented for vote of the people at the November general election, is loosely drawn and full of ambiguous provisions, which by subtle suggestion seek to lull suspicion as to the dangers that lie hidden in the verbiage. . . .

#### EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

*From an Article on "Prehistoric Trephining of the Frontal Sinus," by Frank Albert Burton, M.D., San Diego, Calif.*—For investigation and study, new and most interesting material has been made available through the establishment of the Museum of Man at San Diego under the direction of Dr. Edgar L. Hewitt, Director of the School of American Research. . . .

While studying the nasal accessory sinuses of the skulls in the Museum I came across one of undoubted trephining of the frontal sinus. This gave the incentive, and a careful search through the entire collection resulted in finding two more with trephine openings into the frontal sinus. The study of these specimens, as well as the review of the literature, was most interesting to me and believing it would interest you accounts for this paper today. . . .

*From an Article on "Hookworm and Amoebiasis in California," by C. A. Kofoid, Professor of Zoology, University of California, Berkeley, California.*—Two diseases of parasitic origin which may be expected to appear in the routine of any physician's practice in California are hookworm and amoebiasis. Both are infections primarily of the digestive tract and may be detected by faecal examination, though their symptoms are exceedingly varied, and, especially in the case of amoebiasis, may give no clue to the location and nature of the infection. . . .

*From an Article on "Basal Metabolism in Thyroid Disease, as an Aid to Diagnosis and Treatment, with Notes on the Utility of the Modified Tissot Apparatus," by Albert H. Rowe, M.S., M.D., Oakland, Calif.*—The minimal metabolic change resulting from the continuous organic functions of the body which are essential to life is termed the basal metabolism. This basal metabolism can be measured by a calorimeter either by the direct estimation of the heat produced in the body, or by calculating the heat production from the amount of oxygen used and the CO<sub>2</sub> given off as a result of the oxidation going on in the organism. . . .

(Continued in Front Advertising Section, on Page 26)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

## BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M.D.

Secretary-Treasurer

### Board Proceedings

An unusually large number of examinees appeared for oral examination at the Board office, Los Angeles, on August 11th.

The next regular meeting of the Board will be held at 1020 N St., Sacramento, from October 15th to 18th, 1945.

At the recent meeting held at the Elks Club, Los Angeles, the Board considered petitions for restoration of revoked certificates and also acted on twelve complaints for unprofessional conduct, several of which had been continued from previous meetings.

The Board of Medical Examiners at its regular meeting held in Los Angeles, August 13 to 16, 1945, took the following actions in regard to the status of licentiates:

Ferdinand M. Ferguson, M.D., was found guilty of habitual intemperance on August 15, 1945, and his license was revoked;

Milton Francis Novotny, M.D., was found guilty as charged in Order to Show Cause and his license was revoked on August 15, 1945;

Maurice J. Pullman, D.S.C., was on August 16, 1945, found guilty of alleged illegal advertising, under Section 2409 of the Business and Professions Code, and he was placed on one year probation;

Courtland Rothwell Sanborn, M.D., was on August 16th, 1945, found guilty of narcotic law violation, under Section 2391 of the Code, and his California license was revoked;

Bim Smith, M.D., was on August 15, 1945, found guilty of narcotic addiction under Section 2390 of the Code and his California license was revoked;

Roy Reginald Lessing Sturges, M.D., was found guilty on August 16, 1945, of illegal operation and his California license was revoked.

### News

"Many a woman physician has been wondering during these hectic days on the home front when her services have become much in demand 'What's my outlook when the war is over and the men doctors come back and take over again?' An encouraging answer to this very natural query has just come from the Women's Bureau of the U. S. Department of Labor as result of a survey of post-war opportunities for women in medical services. 'There never has been a time when adequate medical care was available to all the population,' the report states. 'Indications are that the increased demand in the postwar years for physicians of all types will more than offset the initial increase in the supply trained under the accelerated program during the war. General agreement is that women now studying medicine are likely to have greater rather than less opportunity than those who preceded them.' . . ." (San Francisco Chronicle, July 27, 1945.)

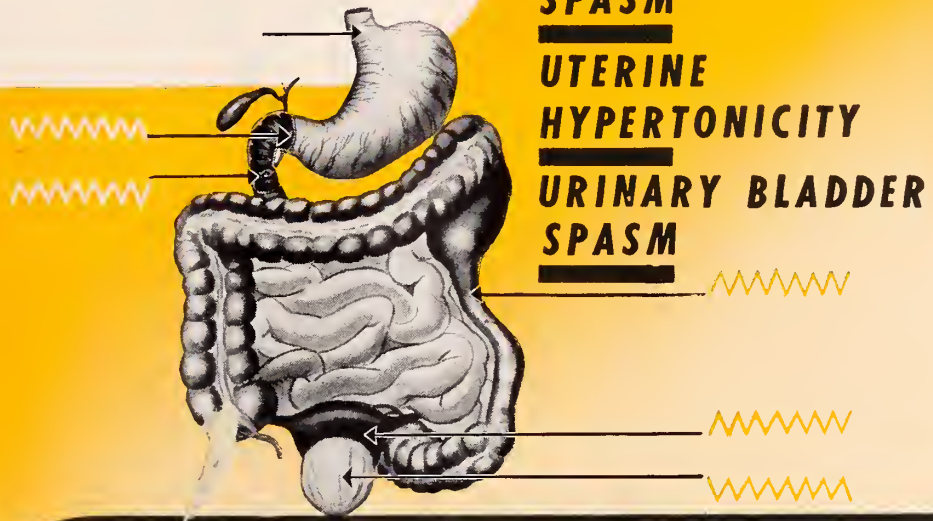
"Senator Sheridan Downey, D., Cal., today introduced a resolution to authorize the military affairs committee

(Continued in Back Advertising Section, on Page 36)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.



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*Highlights for October*

- \* **CHEMOTHERAPY IN OTOLARYNGOLOGY**  
—Wisconsin Medical Journal
- \* **PHYSICAL MEDICINE IN THE REHABILITATION OF PATIENTS WITH WAR NEUROSES**  
—Archives of Physical Medicine
- \* **SURGICAL EXPERIENCES WITH ULCERATIVE COLITIS**  
—Surgical Clinics of North America
- \* **THE MEDICAL TREATMENT OF BILIARY TRACT DISEASE**  
—The Illinois Medical Journal



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distinguishes between inflammatory lesions, tissue destruction, toxemia, and healing or fibrotic lesions.

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Subject material will include applied anatomy, bone pathology, applied kinesiology and orthopedic surgical technique. Traumatology will cover fractures and general surgical problems involving the three cavities: head, chest and abdomen, as well as peripheral nerve and vascular injuries.

*The Course Begins January 7, 1946*

*Fee for the Course Is \$200*

Address your communications to: Chairman, Postgraduate Education, College of Medical Evangelists, 312 North Boyle Ave., Los Angeles 33, California.

**TWENTY-FIVE YEARS AGO**

(Continued from Page 28)

Nourse of the Appellate Court, in which Justice Nourse expressed minor views that Section 2979a of the Political Code is unconstitutional, the section under which the health officer must proceed to make effective the program of the government in stamping out venereal diseases and thereby saving future generations from their ravages.

**Effects of Prolonged Malnutrition**

Prolonged malnutrition is a much more serious medical problem than famine, because it leads to diseases of low resistance, the chief of which is tuberculosis, and to conditions which may take several generations to remedy.—Lord Horder, *J.A.M.A.*, May 6, 1944.





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R. M. Tandowsky (American Heart Journal, January 1945) states:

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Sokolow and Chamberlain (Annals of Internal Medicine, February 1943) state:

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## BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 154)

to make an immediate investigation of what he called hoarding of doctors and dentists by the army and navy." (Washington press dispatch dated June 12; printed Hollywood News, June 12, 1945.)

"A jury in Police Judge Raymond L. Reid's court will decide July 12 whether or not Mrs. Pauline Vigil of 1823 N. Buena Vista St. is guilty of violating the State Business and Professional Code. She pleaded not guilty to three counts of assertedly practicing medicine without a license. The charges were preferred by the Board of Medical Examiners." (Press dispatch from Burbank, printed Hollywood Advertiser, June 28, 1945.)

"One answer to the question of where to get blood and blood plasma for civilians now and in the postwar world is given in a new policy announced by the American Red Cross. The Red Cross will continue to operate for civilians the blood donor service which has been so successful in supplying blood, plasma and albumin to the armed forces. Victims of accidents and burns, mothers in childbirth and other patients desperately needing blood or one of its fractions will not, as in prewar days, have to depend on finding a relative, friend or professional donor with the right blood type . . . Details of the new Red Cross service are given in a report in the forthcoming issue of the *Journal of the American Medical Association*." (Berkeley Gazette, July 6, 1945.)

(Continued on Page 40)

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Herwick, Welch, Putnam and Gamboa\* offer two important conclusions regarding the possibility of irritation after intramuscular injection of penicillin. They are that:

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1. Uniformly high in potency per milligram, and
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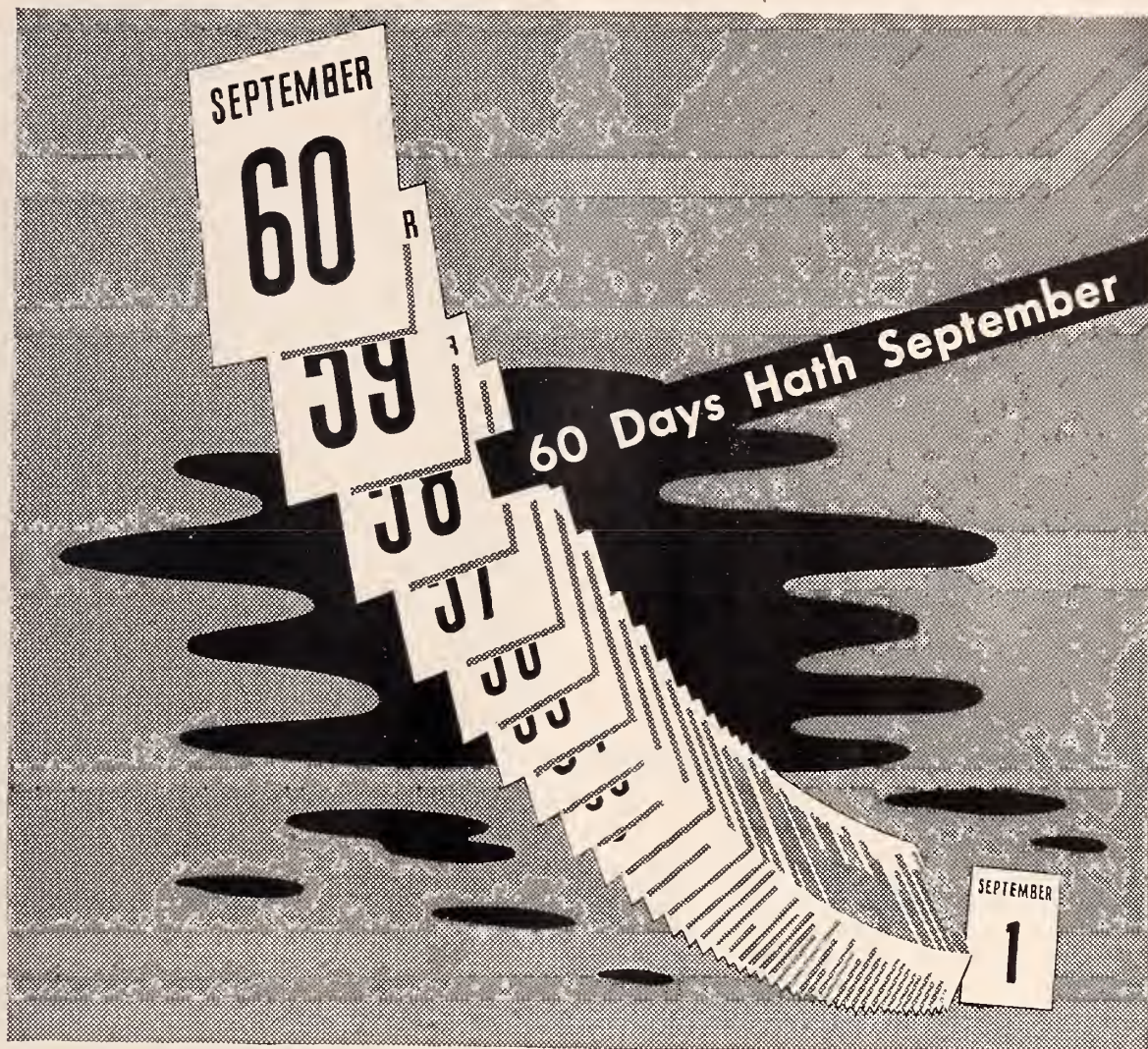
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\*J.A.M.A. 127:74-76 (Jan. 13) 1945.





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DOCTORS DISCHARGED  
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MILITARY POLICY  
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**MEDICAL PROTECTIVE COMPANY**  
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A complete full-time course covering an academic year (9 months), consisting of attendance at clinics, witnessing operations, lectures, demonstrations of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; head and neck dissection (cadaver); clinical and cadaver demonstration in bronchoscopy and facial palsy; refraction; roentgenology; pathology, bacteriology and embryology; physiology; neuro-anatomy; anesthesia; physical therapy; allergy; examination of patients pre-operatively and follow-up post-operatively in the wards and clinics; work in the out-patient department as assistant.

PROCTOLOGY,  
GASTRO-ENTEROLOGY and  
ALLIED SUBJECTS

For Information Address: MEDICAL EXECUTIVE OFFICE, 345 West 50th Street, New York 19

## BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

"Two principals in a doctor-patient shooting fray were 'holding their own' today, hospital authorities said. Dr. Hans E. Schiffbauer, 62-year-old surgeon and heart specialist, was listed as 'holding his own' at California Lutheran Hospital where he is recuperating from bullet wounds from a gun fired by a neighbor patient. Hospital doctors gave him 'a chance to live.'" (Los Angeles Herald and Express, July 23, 1945.)

"Dr. Clyde A. Pierson, San Bernardino osteopath, was granted probation and fined \$1,500 yesterday by Superior Judge Frank A. Leonard for an asserted abortion he performed on a Los Angeles woman. Two of the three abortion counts on which Dr. Pierson was convicted originally by a superior court jury were reversed by the

appellate court and, upon motion from the district attorney's office, were dismissed yesterday by Judge Leonard. Judge Leonard granted probation after issuing a lengthy statement in which he declared that 'it is common hearsay knowledge that the defendant is not the only doctor in this locality rendering a like medical service.' . . ." (San Bernardino Telegram, July 3, 1945.)

## Incidence of Tuberculosis

The source of the spread of tuberculosis in a community is the sum total of all open cases of the disease in the locality. Consequently the greater the opportunities for exposure to open cases the higher the prevalence of tuberculosis morbidity and mortality in a community. The greater prevalence of tuberculosis in the more densely populated areas is reflected in the higher rates for children in these localities.—J. Yerushalmy, Ph.D. and C. Silverman, M.D., Am. Rev. Tbc., May, 1945.



## *In the Activity of the Endocrine Glands*

The depth to which protein permeates the fabric of metabolic life, and the role it plays as "raw material" and component of elaborated secretions is indicated in hormonal composition.

Thyroxine, the active principle of the thyroid gland, is an iodinated phenyl-ether derivative of the amino acid tyrosine. Epinephrine, the active principle of the adrenal medulla, is also a tyrosine derivative. Insulin, as elaborated by the islands of Langerhans, has been isolated in crystalline form and found to be a protein.

Only from the proteins of the foods eaten can the organism derive the protein substances required for these complex purposes.

Among man's protein foods meat ranks high, not only because of the percentage of protein contained, but principally because its protein is of highest biologic quality, applicable wherever protein is required.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

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*Uniform  
Satisfaction*

**Schieffelin  
BENZESTROL**  
(2, 4-di (p-hydroxyphenyl)-3-ethyl hexane)

Clinicians agree that Schieffelin BENZESTROL is a significant contribution to therapy in that it is both estrogenically effective and singularly well tolerated, whether administered orally or parenterally.

"In our hands it has proved to be an effective estrogen when administered either orally or parenterally and much less toxic than diethylstilbestrol at the therapeutic levels" (Talisman, M. R.—Am. Jour. Obstet. & Gynec. 46, 534, 1943)

"During the last two years I have used the new synthetic estrogen Benzestrol in patients in whom estrogenic therapy was indicated. The results have been uniformly satisfactory". (Jaeger, A. S. Journal Indiana State Med. Assn. 37, 117, 1944)

Schieffelin BENZESTROL is indicated in all conditions for which estrogen therapy is ordinarily recommended and is available in tablets of 0.5, 1.0, 2.0 and 5.0 mg.; in solution in 10 cc. vials, 5 mg. per cc.; and vaginal tablets of 0.5 mg. strength.

*Literature and Sample on Request*

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Pharmaceutical and Research Laboratories  
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## THE POTTENGER SANATORIUM and CLINIC

*For Diseases of the Chest*

*Monrovia, California*

AN INSTITUTION FOR DIAGNOSIS AND THERAPY

(Established 1903)

CHOICE rooms and bungalows. Rates moderate and include routine medical and nursing services, interim physical, X-ray and laboratory examinations, ordinary medicines and pneumothorax. A charge is made for the first complete examination.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases. Separate institution for children.

For particulars address:

**THE POTTENGER SANATORIUM AND CLINIC • Monrovia, California**

### Boards of Examiners in the Basic Sciences

Basic science requirements underlying the practice of the healing arts have been established by legislative action in seventeen states and the District of Columbia. A basic science law provides for the establishment of a board of examiners and requires that each person who desires to practice the healing arts appear before that board and demonstrate his knowledge. Such boards are distinct from licensing boards. A certificate of proficiency in the basic sciences does not authorize the possessor to practice the healing art; it enables him only to apply for licensure so to practice.

#### *States Having Basic Science Laws and Year of Enactment*

Arizona .....	1936	Nebraska .....	1927
Arkansas .....	1929	New Mexico .....	1941
Colorado .....	1937	Oklahoma .....	1937
Connecticut .....	1925	Oregon .....	1933

District of Columbia.	1929	Rhode Island .....	1940
Florida .....	1939	South Dakota .....	1939
Iowa .....	1935	Tennessee .....	1943
Michigan .....	1937	Washington .....	1927
Minnesota .....	1927	Wisconsin .....	1925

Connecticut and Wisconsin were the first states to adopt such legislation. Laws were passed in these states in 1925. Other states comprising the group, together with the year of enactment of their basic science law, are recorded in the above table.

The subjects in which examinations are conducted by the respective states and the District of Columbia are shown in table 29. These subjects are specified by statute. The examining boards are not authorized to add any subjects or to refrain from giving an examination in any subject specified by the law. All eighteen boards examine in anatomy, pathology and physiology, sixteen examine in biochemistry, fourteen in bacteriology, eight in hygiene, two in diagnoses and one in public health.

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# AT HOME OR AWAY

## SPOT TESTS

# SIMPLIFY URINALYSIS

### NO TEST TUBES • NO MEASURING • NO BOILING

Diabetics welcome "Spot Tests" (ready to use dry reagents), because of the ease and simplicity in using. No test tubes, no boiling, no measuring; just a little powder, a little urine—color reaction occurs at once if sugar or acetone is present.

### *Galatest*

FOR DETECTION OF SUGAR IN THE URINE

### *Acetone Test* (Denco)

FOR DETECTION OF ACETONE IN THE URINE

### THE SAME SIMPLE TECHNIQUE FOR BOTH

1. A LITTLE POWDER



2. A LITTLE URINE

COLOR REACTION IMMEDIATELY



A carrying case containing one vial of Acetone Test (Denco) and one vial of Galatest is now available. This is very convenient for the medical bag or for the diabetic patient. The case also contains a medicine dropper and a Galatest color chart. This handy kit or refills of Acetone Test (Denco) and Galatest are obtainable at all prescription pharmacies and surgical supply houses.

*Accepted for advertising in the Journal of the A.M.A.*

WRITE FOR DESCRIPTIVE LITERATURE

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163 Varick Street, New York 13, N. Y.

# French Hospital

Geary Boulevard and  
Fifth Avenue  
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**A** general hospital of 225 beds operating an accredited School of Nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and operated by the French Mutual Benevolent Society through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons.

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## THE MENNINGER SANITARIUM

**For the Diagnosis and Treatment of Nervous and Mental Illness.**

## THE SOUTHARD SCHOOL

**For the Education and Psychiatric Treatment of Children of Average and Superior Intelligence. Boarding Home Facilities.**

**TOPEKA, KANSAS**

### The U. S. Pharmacopoeia

The U. S. Pharmacopoeia observes its 125th anniversary this year. For one hundred and twenty-five years, the U.S.P. has hewn to its purpose "to provide standards for drugs and medicines of therapeutic usefulness or pharmaceutic necessity, sufficiently used in medical practice within the United States or its possessions; to lay down tests for the identity, quality, and purity of these; to insure, so far as practicable, uniformity in physical properties and active constituents."

Unique among unofficial publications in this country, the U.S.P. together with its offspring, the *National Formulary* and the *Homeopathic Pharmacopoeia*, although owned and controlled by private groups, have been adopted as national standards by law. Thus the U.S.P. is in an anomalous position. Remarkably enough, there have never been any serious complaints about this situation, largely because the all-important Committee of Re-

vision has always leaned over backwards in making absolutely certain that no taint of private interest should color its decisions. Every safeguard is scrupulously observed, and it would be hard to find anywhere in government service a group more consciously aware of its duty to the public. Except for two executives, all the members serve without pay.

The first edition of the U.S.P., published in 1820, largely resulted from the efforts of one man—Dr. Lyman Spalding. There were several local pharmacopoeias at that time, and the idea of a national book of standards was not unknown, but Dr. Spalding, then practicing medicine in New York, carried the idea through to fruition. He invited medical men from the four sections of the country to send delegates to Washington to embody their ideas into a single volume. The result was a book of standards modeled largely after the London

(Continued on Page 50)

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## ERYSIPELOID

(Rosenbach's Disease)

Not to be confused with streptococcic erysipelas, this extremely painful, and sometimes even fatal infection is caused by *Erysipelothrix rhusiopathiae*. It is observed rather frequently among those brought into contact with animals and fish.

Veterinarians, slaughterhouse-workers, butchers, farmers, bone-button makers, fish-handlers and cooks are most likely to contract the condition, which usually starts as an erythema at the site of primary infection, notably the fingers.

### Now—WELL-TOLERATED TREATMENT WITH *Concentrated* ANTI-ERYSIPELOID SERUM

(PITMAN-MOORE)

#### HOW SUPPLIED

Pitman-Moore Concentrated Anti-Erysipeloid Serum is available in 10 cc. vials. Two to five cc. is usually adequate for the initial dose. In some instances repeated or increased dosage will not be necessary.

Since the disease in animals responds to sero-therapy, the unrefined anti-swine erysipelas serum was employed in human cases, with much success. However, this unconcentrated serum, in effective dosage, leads rather frequently to anaphylaxis and serum reactions.



**REDUCED REACTIONS**—To minimize this objection, Pitman-Moore Laboratories have developed a *concentrated* and *refined* anti-serum for human use, in which the volume is reduced as much as 80%.

*Complete information to physicians on request.*

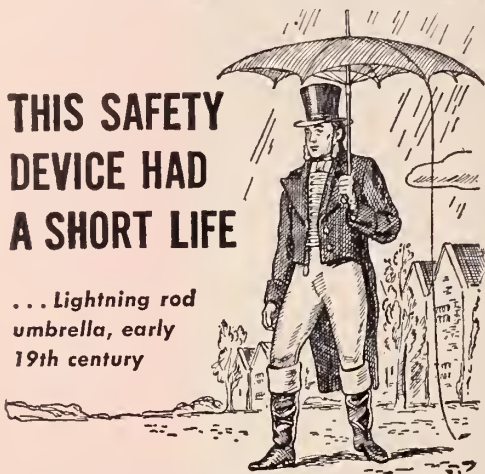
**PITMAN-MOORE COMPANY**

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

Division of  *Allied Laboratories, Inc., • Indianapolis 6, Indiana*

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umbrella, early  
19th century



## But JOHNNIE WALKER is more popular than ever

The enjoyment of  
Johnnie Walker is one  
of life's enduring pleas-  
ures. Smooth as velvet  
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friendship ... each sip  
of this choice scotch  
whisky is a memorable  
occasion.

*Popular Johnnie  
Walker can't be every-  
where all the time these  
days. If occasionally  
he is "out" when you  
call ... call again.*



BORN 1820  
still going strong

# JOHNNIE WALKER

**BLENDED  
SCOTCH WHISKY**



**RED LABEL**

**BLACK LABEL**

*Both 86.8 Proof*  
Canada Dry Ginger Ale, Inc.  
New York, N. Y.  
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**BUY UNITED STATES  
WAR BONDS AND STAMPS**



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It is logical that Iodine has  
been an antiseptic of choice  
for so many years ... because  
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its lasting effectiveness. The  
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trustworthy.

Iodine is preferred in pre-oper-  
ative skin disinfection and in  
treatment of wounds, cuts and  
abrasions.

**IODINE**

*Foe of Infection*

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*Greater discretion  
in selection!*



## Now Stayneral Mineral Supplement May Be Prescribed With Any Of 33 Stayner Vitamins

STAYNERAL has been formulated as a separate high potency multi-mineral tablet so as to take full advantage of the physician's discrimination in selecting the particular vitamin formula required in the treatment of multiple nutritional deficiencies. It may be prescribed alone or in combination with one or more of the 33 Stayner vitamin formulae now available.

There is substantial evidence that vitamins alone are not sufficient to meet dietary deficiencies, but must be taken with minerals for optimum results.

STAYNERAL multi-mineral formula, especially when augmented by Stayner vitamins, is particularly beneficial as a dietary supplement during pregnancy and lactation; in cases of obesity and allergy; for the improvement of bone structure, and in degenerative diseases.

### 7 ESSENTIAL MINERALS

STAYNERAL  
(Stayner No. 7)

EACH COATED TABLET  
CONTAINS:

Calcium Pyrophosphate	2 grs.
(Furnishes Calcium	155 mg.
Phosphorus)	124 mg.
Ferrous Sulfate	
(Iron)	(1 1/2 gr.) 97 mg.
Potassium Iodide (Iodine)	0.1 mg.
Copper Sulfate	2.59 mg.
Magnesium Sulfate	3.24 mg.
Manganese	
Glycerophosphate	3.24 mg.

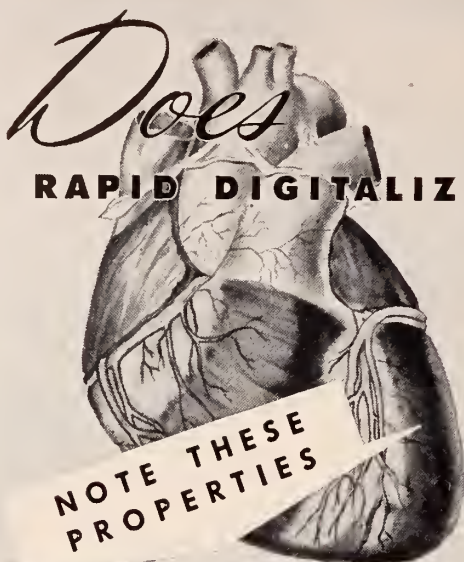
*Six tablets provide 1 1/5 times daily minimum adult requirement of Calcium; 1 times that of Phosphorus; 16.8 times that of Iron, and 4 1/8 times that of Iodine.*

*Available through pharmacists  
—economical to your patients.*



**STAYNER CORPORATION**  
2100 WARD STREET · BERKELEY 5, CALIFORNIA

U.S. Pat. 2,811,111



## RAPID DIGITALIZATION CALL FOR THE

## INTRAVENOUS ROUTE?

Except in the instances when the oral route cannot be employed, or when cardiac action is required in a matter of minutes, rapid digitalization no longer calls for intravenous administration. *With Digitaline Nativelle, digitalization is accomplished by mouth as rapidly as by vein.*

1—Digitaline Nativelle is the chief active glycoside of Digitalis purpurea in pure, crystalline form;

2—Is the most potent oral digitalis body available—1000 times as potent as U.S.P. XII digitalis—1 mg. of Digitaline Nativelle exerts approximately the same cardiac action as 1 Gm. of digitalis leaf;

3—This potency is constant—the ratio between administered amount (in milligrams not "units") and cardiac action does not vary;

4—Digitaline Nativelle is completely absorbed, probably directly from the stomach;

5—Nausea and vomiting due to local irritant action are almost never encountered;

6—Dosage required for oral digitalization is exactly the same as for intravenous;

7—Digitalization is accomplished with virtually the same speed whether administration is by mouth or by vein.

8—The average digitalizing dose is 1.2 mg. and produces its full action in 3 to 6 hours;

9—Provided the patient has not been previously digitalized, or has not received digitalis of any kind for two weeks, the entire digitalizing dose may be given at one time; in urgent cases it should be so administered;

10—The average daily maintenance dose is 0.2 mg.; occasionally 0.1 mg. will suffice, in some instances 0.3 mg. of the drug may be required.

*Physicians are invited to send for clinical test samples and literature*

**VARICK PHARMACAL COMPANY, INC.**

*A Division of E. Fougere & Co., Inc.*

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*Digitaline Nativelle is so reasonably priced that its advantages are within the reach of every patient.*



# Digitaline Nativelle

REG. U. S. PAT. OFF.

**THE ORIGINAL DIGITOXIN, IN  
PURE CRYSTALLINE FORM**



# YOU CAN'T OVERRATE THE VALUE OF CONTROL



In almost every field of endeavor there is striking illustration that control is a prime factor in perfection of performance.

Operating on this principle, the modernly equipped U.D. laboratories evidence unusual quality control in the development and production of fine pharmaceuticals. Extraordinary precautions insure the purity and potency of every preparation bearing the esteemed U.D. label. For example, a special group of doctors, chemists and pharmacists—the Formula Control Committee—not only double-checks each new recipe but the Control Laboratory also tests thoroughly each batch of every finished product.

As a result, you can be certain of products unexcelled in quality whenever you specify U.D. pharmaceuticals. A comparable high quality of service is conveniently available to you and your patients at your neighborhood Rexall Drug Store—characterized by dependability and economy.

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**PURETEST PLENAMINS** . . . Complete vitamin dietary supplement in capsule form. Vitamins A, D, B<sub>1</sub>, C, E, G (B<sub>2</sub>), B<sub>6</sub>, Nicotinamide, Calcium Pantothenate, with Liver Concentrate and Iron Sulfate.

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PHARMACEUTICAL CHEMISTS FOR MORE THAN 42 YEARS  
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UNITED-REXALL DRUG COMPANY AND YOUR REXALL DRUGGIST • Your Partners in Health Service

## A Tribute . . .

To the professional men who use our prescription service:—we wish to express our appreciation of your patience and understanding as war conditions have slowed down our deliveries, have limited some of our most popular materials.

To keep faith with you, our policy continues to be "only the best is good enough for you and your patients."



**RIGGS OPTICAL COMPANY**  
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### Las Encinas Sanitarium . . . . . Pasadena, California

INTERNAL MEDICINE INCLUDING FUNCTIONAL AND ORGANIC NERVOUS SYSTEM DISEASES

Board of Directors: GEORGE DICK, M.D., President; J. ROBERT SANFORD, M.D., Vice-President

Address: STEPHEN SMITH, M.D., F.A.C.P.; CHARLES W. THOMPSON, M.D., F.A.C.P.

Medical Directors, Pasadena, California

### THE U. S. PHARMACOPOEIA

(Continued from Page 44)

Pharmacopoeia, a well-thought-of local standard in existence since 1640. The original group was composed entirely of physicians; it was not until 1840, with the third edition, that pharmacists and scientists began to take a hand in the pharmacopoeia's composition. Since that edition, the work has been carried on preponderantly by pharmacists.

The necessity for standardizing drugs not included in the pharmacopoeia—drugs either too new, too old, or too rarely used, to come within the purpose of the U.S.P.—was realized from the beginning. Dr. Charles Rice, Chairman of the Committee of Revision in 1880, felt the need keenly, and in 1884 the *National Formulary* was adopted

to supplement the U.S.P. Government recognition of these two publications came with the Pure Food & Drug Act of 1906, which cited them as criteria.

The Food, Drug & Cosmetic Act of 1938, replacing the 1906 law, included the Homeopathic Pharmacopoeia, for standards to be applied to homeopathic drugs. This action was in deference to Senator Royal S. Copeland, a homeopathic physician, who labored long and well to get the 1938 Act passed.

Also very useful although not officially recognized, is the annual volume, *New and Nonofficial Remedies*, issued under the direction of the Council on Pharmacy and Chemistry of the American Medical Association. In it are listed and described such proprietary articles, simple nonproprietary and nonofficial substances, and simple pharmaceutical preparations as the Council finds useful and acceptable.



# ANTIMALARIAL REQUIREMENTS OF DISCHARGED VETERANS

*Everywhere in the United States*



Veterans who have been in a malarious region are advised by the medical officers of our Armed Forces to continue taking Atabrine dihydrochloride in suppressive doses (1 tablet of 0.1 Gm. daily) for at least four weeks after the last possible exposure.

If they develop a relapse of malaria, Atabrine dihydrochloride is administered in therapeutic doses (2 tablets every six hours for 5 doses; followed by 1 tablet 3 times daily for six days). Suppressive medication is then continued for three months.

ILLUSTRATED BOOKLET CONTAINING MORE DETAILED INFORMATION SENT ON REQUEST



## ATABRINE

REG. U. S. PAT. OFF. & CANADA

## DIHYDROCHLORIDE

BRAND OF QUINACRINE HYDROCHLORIDE

## THE DRUG OF CHOICE FOR MALARIA



Tablets of 0.1 Gm. (1½ grains), tubes of 15 (plain) and bottles of 25, 100, 500 and 1000 (plain or sugar-coated).  
Also tablets of 0.05 Gm. (¾ grain), bottles of 50, 500 and 1000 (plain). Ampuls of 0.2 Gm., boxes of 5.

WINTHROP CHEMICAL COMPANY, INC.

PHARMACEUTICALS OF MERIT FOR THE PHYSICIAN

NEW YORK 13, N. Y.

WINDSOR, ONT.

# CLAIMS VS. DIFFERENCES

WHAT value have claims of superiority unless there is a difference in formula or process to justify such claims?

Take cigarettes for example.

PHILIP MORRIS Cigarettes are made differently. In the clinic as well as in the laboratory, the advantages of PHILIP MORRIS have been repeatedly observed, repeatedly reported by recognized authorities in leading medical journals. Yes, PHILIP MORRIS claims superiority . . . and that superiority has been proved.\*

May we suggest that your patients suffering from irritation of the nose and throat due to smoking change to PHILIP MORRIS — the one cigarette proved definitely less irritating.



## PHILIP MORRIS

PHILIP MORRIS & CO., LTD., INC.,  
119 FIFTH AVENUE, N. Y.

\*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154  
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

Proc. Soc. Exp. Biol. and Med., 1934, 32, 241  
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.



"but, Doctor, I can't sleep!"

This is a statement that no physician fails to overlook, because regular, adequate sleep is an important factor in the treatment of many clinical conditions.

Therefore, when a sedative is necessary, 'DELVINAL' sodium vinbarbital will provide a night of sound, restful sleep, in the majority of instances, with relative freedom from unpleasant side-effects of excitation or "hang-over."

'DELVINAL' sodium vinbarbital is a mild sedative and hypnotic that is characterized clinically by a safe therapeutic index, a relatively brief induction period and a moderate duration of action.

In addition to its use for the relief of functional insomnia, it is also indicated in general sedation, in the production of preanesthetic hypnosis, psychiatric sedation, obstetric amnesia, and in pediatrics.

Council accepted, 'DELVINAL' sodium vinbarbital is a development of the Medical-Research Laboratories of Sharp & Dohme.

Supplied in dry-filled, colored capsules of three strengths:  $\frac{1}{2}$  grain (brown) in bottles of 100, 500, and 1000;  $1\frac{1}{2}$  grain (orange) in bottles of 25, 100, 500, and 1000; 3 grain (orange and brown) in bottles of 25, 100, 500, and 1000.

Sharp & Dohme, Philadelphia 1, Pa.

**'DELVINAL'**

Sodium Vinbarbital

Sharp  
& Dohme

# LIVERMORE SANITARIUM



• The Hydropathic Department devoted to the treatment of general diseases, excluding surgical and acute infectious cases. Special attention given functional and organic nervous diseases. A well equipped clinical laboratory and modern X-ray Department are in use for diagnosis.

• The Cottage Department (for mental patients) has its own facilities for hydropathic and other treatments. It consists of small cottages with homelike surroundings, permitting the segregation of patients in accordance with the type of psychosis. Also bungalows for individual patients, offering the highest class of accommodations with privacy and comfort.

## GENERAL FEATURES

1. Climatic advantages not excelled in United States. Beautiful grounds and attractive surrounding country.
2. Indoor and outdoor gymnastics under the charge of an athletic director. An excellent Occupational Department.
3. A resident medical staff. A large and well-trained nursing staff so that each patient is given careful individual attention.

*Information and circulars upon request.*

Address: CLIFFORD W. MACK, M.D.  
Medical Director

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## YOUNG'S RECTAL DILATORS

Advocated by many physicians because they have found them a valuable aid to the patient with constipation and those ailments caused by a delayed elimination. They have been found helpful in nervousness or neurasthenia, dysmenorrhea, idiopathic pruritus ani, etc. Not advertised to the laity. Made of bakelite. Obtainable from your surgical house or ethical drug store. Set of 4 graduated sizes, adult \$3.75, children's \$4.50. Write for brochure.

F. E. YOUNG & CO., 432 75th St., Chicago 19, Ill.



## Training Plan on Pacific Diseases

An overall plan for training all personnel on appropriate aspects of prevention, control, diagnosis and treatment of diseases common to the Pacific Area has been approved, Major General George F. Lull, Deputy Surgeon General, announced.

The following training has been planned by the Surgeon General for personnel of medical units being redeployed:

The time allotted to Tropical and Preventive Medicine Problems in the Basic Officers Course at Carlisle has been increased and specially qualified instructors have been assigned to carry out this phase of the program.

The present eight-weeks course in Tropical Medicine given at the Army Medical Center will be reduced to four weeks beginning probably in September and will deal only with diseases common to the Pacific Area.

It is planned that a two-weeks course of instruction in diseases of the Pacific Area will be conducted at Medical Field Service School, Carlisle Barracks, Pennsylvania, to begin on or about August 13, 1945, for unit surgeons, medical inspectors, chiefs of medical services, and other selected officers from units of the three major forces

being redeployed. Instruction will include the prevention, control, treatment, and diagnosis of malaria, dengue, filariasis, Japanese B.—encephalitis, kalaazar, scrub typhus, louse and flea-borne typhus, relapsing fever, plague, bacillary dysentery, amebiasis, schistosomiasis, cholera, salmonella infections, bacterial food poisoning, venereal diseases, trenchfoot, nutritional deficiencies, dermatological conditions and other miscellaneous disease problems to be encountered in the Pacific Area. It is planned to assign a group of highly specialized, well-qualified instructors to the Medical Field Service School, Carlisle Barracks, Pennsylvania, to handle the instruction in the two-weeks course.

Upon completion of this course of instruction, officers will be expected to conduct training programs in the appropriate aspects of the prevention, control, treatment, and diagnosis of these diseases for all personnel present in their units during redeployment. A training guide is being prepared for use in this unit personnel training.

In addition, a supplementary program of instruction for nurses of units being redeployed will be conducted at the training centers to cover the nursing problems associated with the diseases to be encountered in the Pacific Area.





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### Sir Alexander Fleming—Discoverer of Penicillin

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(Continued on Page 62)



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### SIR ALEXANDER FLEMING DISCOVERER OF PENICILLIN

(Continued from Page 60)

view Sir Alexander remarked that there was danger of "educating the microbe to resist penicillin." In his talk at a dinner tendered him by penicillin producers and the following evening he again referred to this fear. "The greatest possibility of evil in self-medication is the use of too small doses so that instead of clearing up the infection, the microbes are educated to resist penicillin and a host of penicillin-fast organisms is bred out." But he went on to express the hope that this danger could be averted.

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Dr. Coghill, of the Northeastern Research Laboratories in Peoria, once described the search for the best-producing strain of *Penicillium notatum*. Among other things, Air Forces pilots were requested to bring back samples of mold from the "four corners of the earth," but in the end, the highest yield of penicillin was found on a moldy cantaloupe rescued from a Peoria backyard!

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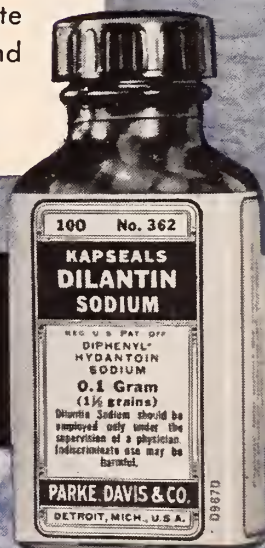


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(Continued from Page 3)

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University of California Medical Library, Medical Center, San Francisco 22. Phone MONTrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WESt 8000, Extension 75.

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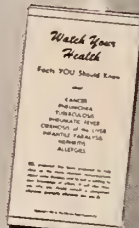
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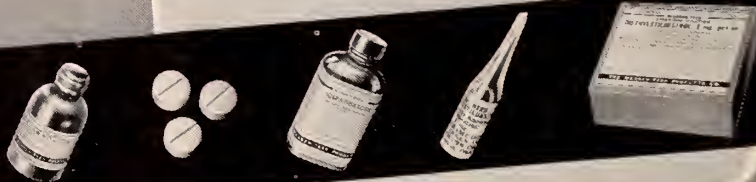


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## BOOK REVIEWS

### BOOKS RECEIVED

**Voluntary Health Agencies: An Interpretive Study.** By Selskar M. Gunn and Philip S. Platt, with a Foreword by Louis I. Dublin under the auspices of the National Health Council. Cloth. Price, \$3.00. Pp. 364. New York: The Ronald Press Company, 1945.

**Diseases of the Breast: Diagnosis. Pathology. Treatment.** By Charles F. Geschickter, M.A., M.D., Lieut. Commander, Medical Corps, United States Naval Reserve, Director of the Francis P. Garvan Cancer Research Laboratory; Pathologist, St. Agnes Hospital, Baltimore; with a Special Section on Treatment in Collaboration with Murray M. Copeland, A.B., M.D., F.A.C.S., Instructor in Surgery, Johns Hopkins Medical School; Visiting Surgeon and Assistant Oncologist, University Hospital, University of Maryland Medical School; Visiting Oncologist, Baltimore City Hospitals. Second Edition. Cloth. Price, \$12.00. Pp. 826 with 593 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1945.

**A Primer of Electrocardiography.** By George Burch, M.D., F.A.C.P., Associate Professor of Medicine, Tulane University School of Medicine; Senior Visiting Physician, Charity Hospital; Consultant in Cardiovascular Diseases, Ochsner Clinic; Visiting Physician, Touro Infirmary, New Orleans; and Travis Winsor, M.D., Instructor in Medicine, Tulane University School of Medicine; Assistant Visiting Physician, Charity Hospital, New Orleans. Cloth. Price, \$3.50. Pp. 215, illustrated with 235 engravings. Philadelphia: Lea & Febiger, 1945.

**Nitrous Oxide-Oxygen Anesthesia: McKesson-Clement Viewpoint and Technique.** By F. W. Clement, Major M.C. (Continued on Page 12)

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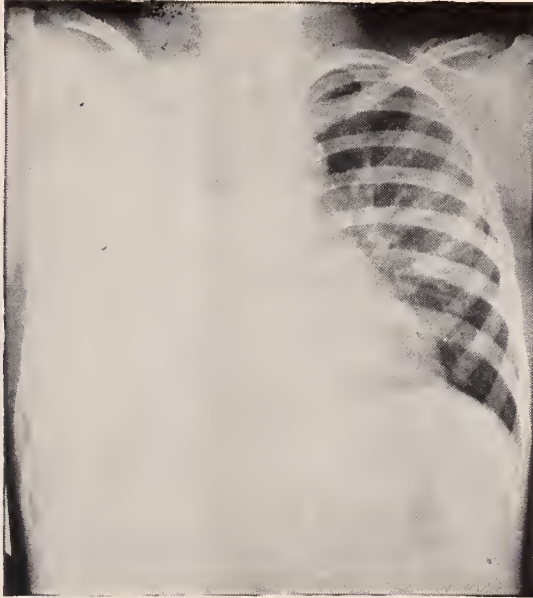
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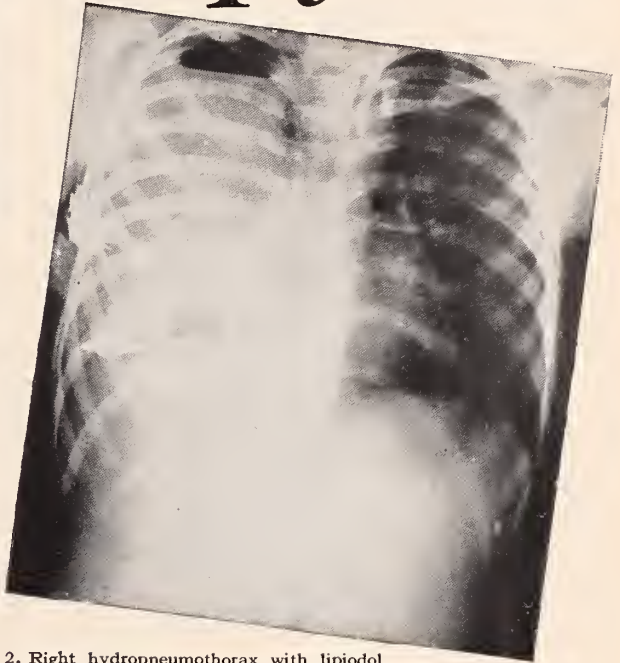
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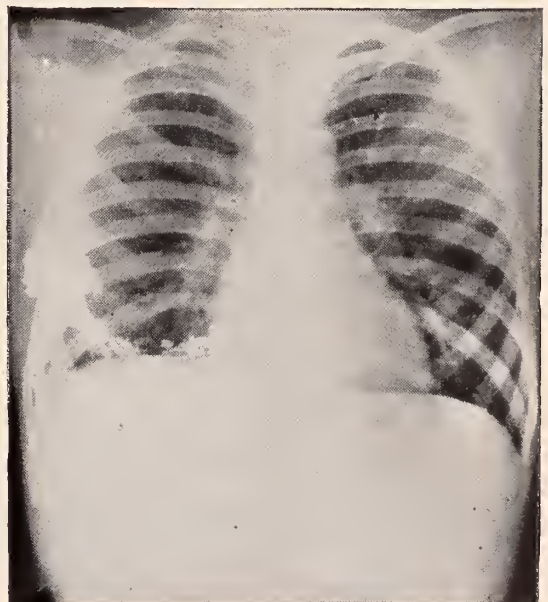
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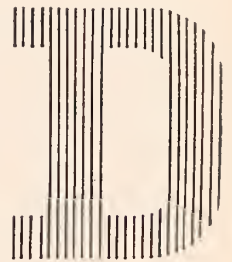
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1. Am. J. Dis. Child. 66:1 (July) 1943.
2. Nebraska State Med. J. 29:15 (Jan.) 1940.

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**Don't Be Afraid! How to Get Rid of Fear and Fatigue.** By Edward Spencer Cowles, M.D., Director of the Park Avenue Hospital, New York; Fellow of the American Association for the Advancement of Science; Fellow of

the New York Academy of Sciences. Foreword by Maurice Maeterlinck. Cloth. Price, \$2.00. Pp. 251. New York, Chicago: Wilcox & Follett Company, 1945.

**Essentials of Clinical Allergy.** By Samuel J. Taub, M.D., Professor of Medicine, Cook County Graduate School of Medicine; Attending Physician in Medicine, Cook County Hospital; Fellow of the American Academy of Allergy; formerly, Assistant Professor of Medicine, Rush Medical College, of the University of Chicago. Cloth. Price, \$3.00. Pp. 198. Baltimore: The Williams & Wilkins Company, 1945.

**Clinical Parasitology.** By Charles Franklin Craig, M.D., M.A. (Hon.), F.A.C.S., F.A.C.P., Colonel, United States Army (Retired), D.S.M., formerly Director, Army Medical School, and Assistant Commandant, Army Medical Center, Washington, D.C.; Emeritus Professor of Tropical Medicine in the Tulane University of Louisiana, New Orleans, Louisiana; and Ernest Carroll Faust, M.A., Ph.D., Pro-

(Continued on Page 16)

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### BOOKS RECEIVED

(Continued from Page 12)

essor of Parasitology in the Department of Tropical Medicine, Tulane University of Louisiana, New Orleans, Louisiana; Consultant to the Secretary of War, Army Epidemiologic Board on Epidemic and Tropical Diseases; Consultant U. S. Public Health Service; Honorary Consultant, Army Medical Library. Fourth edition, thoroughly revised. Cloth. Price, \$10.00. Pp. 871, illustrated with 305 engravings and 4 colored plates. Philadelphia: Lea & Febiger, 1945.

**Virus As Organism.** Evolutionary and Ecological Aspects of Some Human Virus Diseases. By Frank MacFarlane Burnet, M.D., F.R.S., Director, Walter and Eliza Hall Institute of Research in Pathology and Medicine, Melbourne, Australia. Cloth. Price, \$2.00. Pp. 134. Cambridge, Massachusetts: Harvard University Press, 1945.

**Pulmonary Edema and Inflammation.** An Analysis of Processes Involved in the Formation and Removal of Pulmonary Transudates and Exudates. By Cecil K. Drinker, M.D., D.Sc., Professor of Physiology, School of Public Health, Harvard University, Boston, Mass. The Nathalie

Gray Bernard Lectures Delivered at The Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, North Carolina, in December, 1944, Together with a Fifth Chapter on Artificial Respiration. Cloth. Price, \$2.50. Pp. 106, illustrated. Cambridge, Massachusetts: Harvard University Press, 1945.

### BOOK REVIEWS

**Voluntary Health Agencies: An Interpretive Study.** By Selskar M. Gunn and Philip S. Platt, with a Foreword by Louis I. Dublin, under the auspices of the National Health Council. Cloth. Price, \$3.00. Pp. 364. New York: The Ronald Press Company, 1945.

Recommending the revitalization and strengthening of the voluntary health agencies of this country, the National Health Council, an affiliated group of 18 health organizations, today (Monday, September 17th) issued a report entitled, "Voluntary Health Agencies—An Interpretive Study" by Selskar M. Gunn and Dr. Philip S. Platt. The report, supported by a grant from the Rockefeller Foundation, involved field work and research for

(Continued on Page 17)

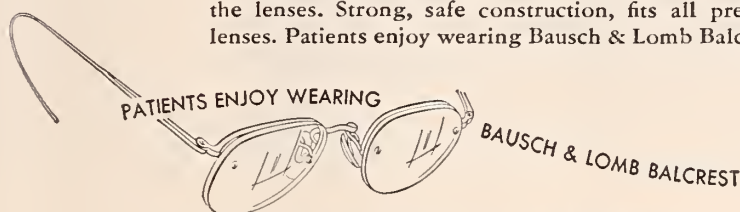




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### BOOK REVIEWS

(Continued from Page 16)

three years on 568 voluntary agencies in sixty-five cities and twenty-nine states. The purpose of the study was to ascertain the present scope and effect of the work of the 20,000 voluntary health agencies in the United States, and to determine how they can obtain greater effectiveness in their respective areas. These agencies (exclusive of the Red Cross) at present have budgets of some 50 million dollars a year and enlist the active support of over 300,000 board members and professional advisors, as well as an even greater number of volunteer workers.

The results of the study emphasize the fine record of achievement of these agencies and credit them with much of the progress in public health during the 20th century. These voluntary health agencies, the book states, "represent a form of enterprise that is likely to have a permanent and valuable rôle in our civilization." It asserts,

however, that their independent and uncoordinated attacks upon specific diseases, without central or unified planning, have often resulted in confusing the public as to the goals of individual and public health. Organizational deficiencies on the local level have detracted from the effectiveness of the work, have made for occasional duplication of effort and conflict between agencies, with resulting lack of balance in meeting emergent needs.

"The most striking fact is the marked unevenness of the voluntary health movement in this country," said Dr. Louis I. Dublin, Chairman of the Study, in his preface to the report. "Excellent societies abound; but many are inadequate. Because the development was a spontaneous growth in a variety of uncovered fields to meet newly organized needs, the movement necessarily has lacked central direction and planning."

The major recommendations of the Gunn-Platt report

(Continued on Page 26)

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\*Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:372 (July) 1944.

Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

Lockwood, S. J.; White, W. L., and

Murphy, F. D.: The Use of Penicillin in Surgical Infections, Ann. Surg. 120:311 (Sept.) 1944.

Kenney, J. F.: Report of a Case of Staphylococcus Bacteremia Treated with Sulfadiazine and Penicillin, Rhode Island M. J. 27:663 (Dec.) 1944.

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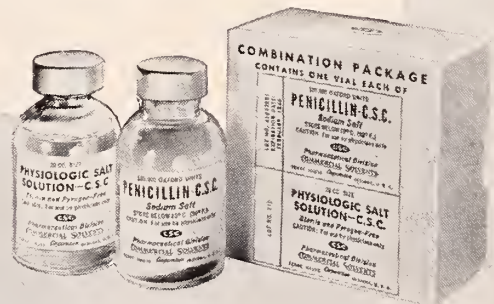
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\*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32, 241; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.



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Salinger, S.: Arch. Otolaryng. 4:40, 324,  
noting Bax, H.E.H.: M. J. Australia 2:126.

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### BOOK REVIEWS

(Continued from Page 17)

deal with suggestions for the improvement of the efficiency of the local agency and its more complete coordination with the activities of the national organizations. Such revitalizing of the local voluntary health agencies, it suggests, can be accomplished by:

1. A searching self-analysis by each agency of its present goals, activities, functions, methods and relationships. The report includes a "Self-Evaluation Schedule" by which each organization may check itself against standards of effectiveness.

2. The strengthening of executive and board membership by each agency.

3. The organization in each town or city of a Health Council, representing all related local agencies, to effect

coördinated health planning. The report recommends that demonstrations of such organizations be launched in a few cities.

4. The simplification and unification of appeals for public support.

5. The transfer of appropriate activities to the official public agencies and the recognition of the primary position of leadership of the official agency.

Finally, the authors recommend the pooling of the present separate competitive and confusing money-raising appeals of the separate agencies into a nationwide campaign, effective on the local, state and national levels. It advocates the preparation of a single combined health agency budget for every city, town and village. A technique similar to that of the National War Fund should be adopted for financing voluntary health work on a national basis.

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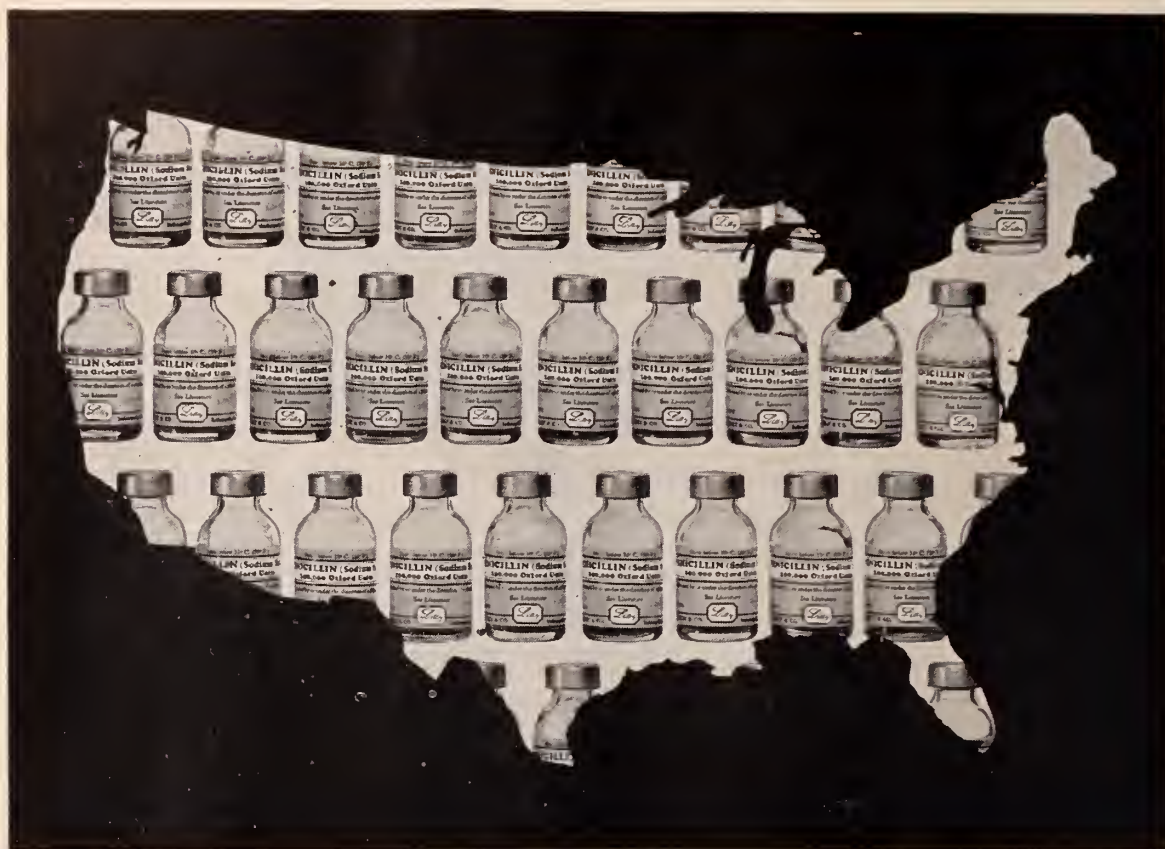
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EDITOR . . . . . GEORGE H. KRESS, M. D.

### Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

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R. H. Sundberg.....	San Diego	1948
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**Leaflet Regarding Rules of Publication.**—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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## EDITORIALS

### HIGH COSTS OF SERIOUS ILLNESS OR INJURY—ARE THEY NOT, ABOVE ALL ELSE THE HOSPITALIZATION EXPENSES?

**Some Premises and Conclusions Regarding Psychologic and Other Reactions to Hospitalization Costs.**—On some things, today, referring to costs of unforeseen illnesses and injuries, lay citizens and physicians are or should be agreed. Included among such factors may be mentioned:

(a) The expense of care for unpredictable illness often brings financial impoverishment to many families belonging to middle class or lower income groups;

(b) Present-day expenses are in very good part the result of existing systems of medical practice; in which, in order to provide a better quality of medical care, sick and injured persons are promptly sent to hospitals for treatment instead of being served in their homes, as in former years.

(So much have Americans changed in this respect, that even childbirth is now construed to be an event that should take place in a hospital, rather than in a home environment.)

(c) Physicians today, in metropolitan, and also in large and small cities and communities, carry on their major work in and under hospital conditions. Citizens have accepted this change, and rarely object when it is advised that they need hospital care for their illnesses or injuries, and, those who do, hesitate rather because of hospital expenses, than from other reasons.

(d) Even though citizens be willing to be sent to hospitals, that fact does not lessen their unhappiness when the calamitous hospital bills or reckonings for hospital services rendered, are submitted to them for payment.

(e) As a consequence, it is not surprising that thousands of citizens have come to the conclusion that something is radically wrong in medical practice, making them willing to lend kindly ears to proposals whereby the unforeseen and heavy hospital expenses, so often incident to medical care, may be minimized or entirely done away with.

Thus it happens that socialized and state medicine secure disciples and advocates.

And it is just here that specious and other propagandists for idealistic, theoretical or leftist changes,—no matter what may be their motivating reasons—are able to become a real part of the problem, since they lay the foundation for plans whereby state (governmental) medicine, or so-

called socialized medicine, would enter and supplant medical practice as it has been evolved and carried on in the United States.

\* \* \*

#### **Unhappiness Results from High but Natural and Unpreventable Hospitalization Costs.—**

If what has been above stated be true, it is logical to assume that citizens are not unhappy with the quality of medical care given in hospitals; but rather, are much dissatisfied with the expenses resulting from such service.

Families of physicians are no exception to this reaction, because medical men have no more relish for hospital expenses than their lay brethren; even though they can better appreciate than lay persons, why hospital expenses are what they are, and how little possibility there is of bringing maintenance costs of such institutions to a lower level—that is, to a level so moderate, that expense of hospital care would approximate those of home care, with members of the family or practical nurses giving care to the patient.

\* \* \*

#### **Hospital Costs Are Analogous to Costs in First Class Hotels, plus Additional Costs for Special and Extra Equipment and Personnel Made Available.—**

What has been above stated is not intended to insinuate in relation to services rendered, that hospital expenses are excessive or extortionate. On the contrary, it is believed that hospital management in America has made a splendid record for efficiency. The wonder is, when all things are considered, not that the costs of hospitalization are as high as they are, but rather, that it is possible in most hospitals, to do as much as is done, for the money that is received in payment from patients.

It is unfortunate that so many citizens seem to think, because they are unfortunate enough to be ill, even though they may have needed and wanted hospitalization care, that the hospitals should charge little or nothing for the services they have rendered! (We see here the relation to the impression held for many years by some persons, that a physician is a servant of the people, to be available day or night, seven days in the week, even when there is no honest endeavor or even intention, to pay for services that may have been rendered.)

Very few hospitals have endowment or other funds that make it possible for them to accept patients belonging to different income classes, without asking return compensation.

Hospitals have arisen in all portions of the United States, in response to modern-day needs and trends. It must be remembered, however, as already stated, that hospitals in one sense, are only hotels whose clients are sick and injured citizens.

All the expenses incident to hotels apply therefore in good part to hospitals, plus many more that could be mentioned, incident to specialized equipment and personnel needed for the proper care of individuals who are more or less incapacitated by illness or injury.

#### **The Solution of the Problem of High but Necessary Hospital Costs Is Found in Prepayment Voluntary Insurance Coverage.—**

Having established the fact that modern-day medical care comprehends inclusion of hospital treatment and that such hospitalization is expensive—so much so that its utilization can and at times does bankrupt family groups, the question arises:—Is there no method whereby this unforeseen but necessary expense can be covered, so that its untoward and deplorable financial consequences to many families may be ameliorated or done away with?

Fortunately, here the answer can be in the affirmative.

Yes, through the application of the *prepayment insurance principle*—if a sufficient number of citizens align themselves in the mass effort—it is possible for citizens—inclusive of even the low income groups—at comparatively small cost, to protect themselves against the hazards of unforeseen hospital costs—just as they in similar manner and for like reason, protect themselves and their homes against fire loss, their automobiles from accident expenses, and so on.

That such hospital coverage is not an idle dream, but a realization readily accepted by the public, is amply shown in the phenomenal growth in the last few years of the Blue Cross Hospitalization plans that are now operative in almost all states of the Union.

Think of it—starting about the year 1937, in a small mutual school teachers' experiment at Dallas, Texas, this movement has now grown until today, more than 18 million citizens of the United States carry Blue Cross hospitalization protection!

(For recent articles in CALIFORNIA AND WESTERN MEDICINE, dealing with Hospital and Blue Cross development, see in following issues: July, 1945, p. 38 and 45; August, 1945, pp. 88 and 92; September, 1945, pp. 143 and 144.)

In California, three Blue Cross Hospitalization groups are successfully carrying on their respective work. The Association of California Hospitals has plans under way to combine their efforts for even greater results.\*

\* \* \*

#### **Acceptance of Hospitalization Coverage Is the Foundation and Forestructure of Medical Service Coverage.—**

A scanning or perusal of those references, with reflection on the significance of the figures presented, and the almost startling nature of pre-payment hospitalization growth should convince skeptical readers that hundreds of thousands of American citizens have accepted hospitalization insurance coverage, just as in past years, they have turned to protection against fire, automobile and other like hazards, in which mass union and coöperation was necessary in order to bring into play, protection of the person who may suffer an individual loss.

\* For other comment, see in current issue of CALIFORNIA AND WESTERN MEDICINE, on page 181 (Minutes, Item 2).



The way to best combat "compulsory sickness insurance" (compulsory governmental and state medicine insurance) is to prove that *voluntary hospitalization and medical coverage* is not only acceptable, but preferred and used by the majority of citizens. That objective can be attained if physicians everywhere will give wholehearted support to non-profit hospitalization and medical coverage plans exemplified by Blue Cross and California Physicians' Service.

#### COUNTY MEDICAL ASSOCIATION BULLETINS OF CALIFORNIA

**California Medical Association Is Proud of Bulletins of Its County Medical Societies.**—During the last several years the larger component county units of the California Medical Association, and in particular, Los Angeles, San Francisco, Alameda, Santa Clara and San Diego, have been printing *Bulletins*; in fact, on occasions, of such size as to be classed as small medical journals.

In the August issue of CALIFORNIA AND WESTERN MEDICINE mention was made of the latest addition to this group of county publications; namely, *The Bulletin of the Alameda County Medical Association*.

If it were possible to permit every member of the California Medical Association to receive at least once each year a copy of the respective *Bulletins*, we are certain their perusal would be provocative of increased interest in organized medicine.

*The Bulletin of the Los Angeles County Medical Association* is the largest of the group and is the source of a very considerable annual income to that component county society.

Each of the *Bulletins* presents from month to month information of much importance to local members, and in addition, the editors of the respective publications are generous in their consideration of problems confronting organized and scientific medicine. The wholehearted service rendered by the Publication Committees of these *County Bulletins* is worthy of praise, and the Editorial Board of CALIFORNIA AND WESTERN MEDICINE esteems it a privilege to call the attention of members of the California Medical Association to the services that are so rendered.

Good wishes are extended to these publications and also to the editors of the mimeographed and other *Bulletins* supported by others of the component county medical units of the C.M.A. Good wishes to each and all of them.

#### AMERICAN MEDICAL ASSOCIATION MEMBERSHIP STATISTICS

**California Leads All States in Percentage of J.A.M.A. Subscriptions.**—In its issue of September 29, 1945, the *Journal of the American Medical Association*, commencing on page 360, prints items from the report of the A.M.A. Board of Trustees. In Table I on "Approximate Count of Fellows and Subscribers on the *Journal Mail-*

ing List January 1, 1945," statistics are given for the various states.

California is credited not only with 4,741 Fellows (Fellows of the A.M.A. are members of the state medical associations who subscribe in advance for the *J.A.M.A.*, and apply at the same time through a state medical association office for A.M.A. Fellowship), but also with 4,475 subscribers, making a grand total of 9,216 A.M.A. Fellows and *J.A.M.A.* subscribers for California. New York, of course, has a larger number, but Pennsylvania has a total of only 8,367; Illinois, 7,023; Ohio, 4,774.

Table 2 dealing with "Percentage of Physicians Receiving the *Journal of the A.M.A.*" based upon number of physicians credited with residence in California according to the 17th Edition of the *A.M.A. Directory*, gives California a total of 9,216 resident California physicians who receive the *J.A.M.A.*, and a total of 12,365 physicians credited with residence in California, thus making the approximate percentage of California physicians who receive the *J.A.M.A.*, 75 per cent.

This is the highest percentage recorded for any one of the states of the Union! The next highest percentage is credited to Utah with 72 per cent, followed by New York, with 65 per cent. Maryland with 64 per cent, then by Arizona and Nevada with 63 per cent, and Pennsylvania with 62 per cent. Massachusetts is given 53 per cent.

Not so bad for the "Wild and Woolly West"?

\* \* \*

**A.M.A. Library Report.**—Concerning the work of the A.M.A. Library, at 535 North Dearborn, Chicago, the following information is given.

#### A.M.A. Library

Requests for the loan of 10,836 periodicals were received and filled by the Library of the American Medical Association in 1944. The requests came from physicians in military service in this country and overseas and from civilian physicians in each of the forty-eight states. Chicago libraries also availed themselves of the service to a considerable extent, the American College of Surgeons having had the loan of 498 periodicals, the Medical Library of Northwestern University School of Medicine 172, the John Crerar Medical Library 338 and the University of Illinois School of Medicine 45. Periodicals and miscellaneous medical reprints were lent to 291 physicians serving with the armed forces.

About 2,000 package libraries were lent during the year. Approximately one-fourth of the requests for this service came from physicians in the various military services of the United States.

The subjects most frequently requested during the year were the Rh factor; penicillin; military medicine, including various phases of tropical medicine, aviation medicine, burns and malaria; blood pressure; sulfonamides; anesthesia, and blood transfusion.

Approximately 200 requests were received from physicians overseas, who stated that they were desperately in need of material on certain subjects. Miscellaneous reference questions numbering 4,500 were answered by letter and telephone.

1 1 1

**Why Not Similar Reports from California Libraries?**—It would be interesting if similar reports along analogous lines could be sent to the OFFICIAL JOURNAL of the California Medical Association by the Lane Library of Stanford University, University of California Medical Library, and the Library of the Los Angeles County Medical Association.

The *J.A.M.A.* membership and subscription figures above given should be gratifying to members of the medical profession of California, since they indicate a special interest, not only in scientific, but in organized medicine.

It would be interesting to know to what extent the interest created among California physicians through the continued endeavors made in the California Legislature to promote compulsory sickness insurance plans may have played a part in the creation of the high percentages which are credited to California in regard to A.M.A. Fellowships and *J.A.M.A.* subscriptions.

## EDITORIAL COMMENT†

### HYBRID YEASTS

Demonstration that there is both sexual and asexual reproductive cycle in yeasts, suggested to earlier investigators the possibility of producing desirable new combinations of usable properties in industrial yeasts of hybridization.<sup>1</sup> For example, no natural yeast is capable of fermenting both lactose and maltose.<sup>2</sup> It was conceived that if a lactose-fermenter could be mated with a maltose-fermenter, the resulting hybrid would be of practical industrial interest.

The sexual cycle varies with different yeasts, and is usually more complex than sexual reproduction in higher plants. In 1918 Kruis and Satava<sup>3</sup> of Czechoslovakia showed that the ordinary vegetative cells of *Saccharomyces cerevisiae* are diploid in character, i.e., they have a double number of chromosomes. Under certain unfavorable conditions these diploid cells may segment into four haploid cells, each containing a single number of chromosomes. These ascospores may germinate to produce small round haploid cells, easily distinguishable from ordinary vegetative cells by gross colony structure.

Lindegren<sup>4</sup> of the Henry Shaw School of Botany, Washington University, St. Louis, Mo., subsequently found that these small haploid cells often unite to reform large diploid cells, provided the haplophase cells are of complementary "sex" or mating types. Two mating types were recognized by him. "Legitimate" reproduction takes place by the union of haplophase cells of opposite "sex." "Illegitimate" progeny are formed by "homosexual" union. The illegitimate diploids are usually smaller than legitimate diploids, though they are at times fully capable of growth and fermentation. They, however, usually do not sporulate, but often form fairly stable vegetative cultures, if grown under conditions that do not necessitate sporulation. In addition to these two "sexes" there are usually a number of "neuter" haploids which do not mate.

The first successful hybridization of different species of yeast was reported in 1935 by Winge and Lanstsen.<sup>5</sup> By means of a micromanipulator they placed a haploid ascospore from one strain of yeast in contact with an ascospore from another strain. When all conditions were favorable, "copulation" with exchange of nuclear material took place between the two ascospores, followed by their fusion to produce a diploid vegetative cell. A simpler hybridization technique was afterwards developed by Lindegren,<sup>2</sup> who mated different haplophase cultures, by placing a large drop of a heavy broth suspension of each culture together in a test tube. The mixtures were incubated for 24 hours at 23°C., and the desired hybrids isolated by plating methods.

By this technique Lindegren produced numerous relatively stable hybrid yeasts of promising industrial value. Medical interest, however, will presumably center on his more recent attempts to improve vitamin production by such hybridization methods.<sup>6</sup> He found, for example, that *S. carlsbergensis* is capable of synthesizing large quantities of biotin and pantothenic acid, but is unable to synthesize pyridoxine. *S. cerevisiae* synthesizes large quantities of pyridoxine, but does not synthesize biotin or pantothenic acid. He was able to bring about conjugation between these two species. The resulting hybrid was stable and synthesized all three vitamins in large quantities. In a similar way he found that *S. globosus* is capable of synthesizing pantothenic acid, but is incapable of producing thiamin. An unstable hybrid was made between this yeast with *S. cerevisiae*, and backcrossed with *S. cerevisiae*. The resulting second generation hybrid was stable and a good synthesizer of both thiamin and pantothenic acid.

Burkholder<sup>7</sup> of the Osborn Botanical Laboratory, Yale University, found that of 163 strains of commercial yeasts examined by him, nearly half were deficient synthesizers of three or more essential members of vitamin B complex. Nearly 90 per cent were deficient in the production of at least one essential member. The possibility of improving these deficiencies, therefore, is of wide practical interest.

P. O. Box 51.

W. H. MANWARING,  
Stanford University.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.



### PREVENTIVE AND PUBLIC HEALTH ASPECT OF RHEUMATIC FEVER IN CHILDREN\*

One of the first references to rheumatic heart disease was made in 1789, when Jenner reported to the Fleece Medical Society "Concerning diseases of the heart following acute rheumatism, illustrated by dissections." During the past twenty years, pathologists have demonstrated that rheumatic fever is a systemic disease, probably an infection, producing lesions throughout the body. The heart seems particularly susceptible, both to initial injury and later permanent scarring, and it is this fact which makes rheumatic fever a disease of exceptional importance in the field of public health.

As Swift says:

"Compare this disease with poliomyelitis—both killing only a small number in the initial attack—one crippling obviously and one insidiously—one conferring immunity and the other presenting recurring attacks with increased cardiac crippling. The economic importance of rheumatic fever is much greater than that of poliomyelitis, but the relative attention given them by the lay public, health authorities and vital statisticians is in striking contrast. Searching among reported deaths from heart disease gives only an inkling of the relative part played by rheumatic fever."

Rheumatic fever today is one of the foremost health problems of childhood. Between the ages of 5 and 9, deaths from it are outnumbered only by those of the four principal communicable diseases of childhood. Between 10 and 14, it is the leading cause of death; between 15 and 24 it is second only to tuberculosis.

There is confirmatory evidence of the presence of rheumatic heart disease following rheumatic fever with mild or unnoticed symptoms, and since the period of active rheumatic fever may be deceiving in its apparent mildness, great care should be given to accurate observations and diagnostic technique. How approach this problem? We do not know the specific etiologic agent. However, we do have many helpful facts: we know that there is a strong familial tendency towards the disease; 8 per cent to 10 per cent of the exposed persons in rheumatic families acquire the disease as against 3 per cent in control families. There is also possibly an hereditary factor. We know that the first attack occurs most commonly between four and fifteen years, and is rarely seen before two years or after twenty years. We know that the peak of attacks is in late winter and early spring and that damp, cold climates seem most unfavorable. We know that there is a close association with the streptococcus and that sore throat and respiratory infections are especially apt to incite trouble; also and probably most important of all from the public health and preventive standpoint are the factors of damp and crowding, malnutrition and fatigue, lack of sunshine, inferior medical care and inadequate clothing.

Rheumatic fever is a chronic and recurrent disease requiring long and expensive medical and institutional care. Any control program should

center around the "Rheumatic family" and should place emphasis upon case finding.

The program of prevention should cover many phases. We must strive to prevent the disease, to prevent heart damage once the disease has occurred and to prevent recurrences of the infection following the initial attack. To accomplish these things we must wage a campaign for educating the general public. We must support research to determine etiology, chemotherapy and immunotherapy. We must initiate programs for case findings, must furnish diagnostic centers for patients and provide hospital and convalescent care for the patients. Hospitals are best for the child in the acute stage, but for convalescence the rest home for convalescent rheumatics divided into small units and carefully guarded against upper respiratory infection is best. It is possible that for a period of several years anyway this disease is not cured but merely arrested, showing here a similarity to tuberculosis. It has been shown by Stroud, Martin, Swift and others that even in very intelligent homes and in those with higher incomes, it is difficult to keep a child on proper rest routine after he has begun to feel better and to prevent emotional problems among the family group. How much more difficult it is for those returning to unfavorable home conditions is shown by the fact that these have four times higher incidence of recurrence than those returning to good living conditions.

When the period of active infection is arrested, the task is just begun. Easily accessible facilities must be present for careful periodic check-ups of the patient and his family and for the prompt correction of medical, surgical or social pathology as it arises.

In 1939, the U. S. Department of Labor set aside certain Federal funds for the purpose of developing state programs for children with heart disease. These funds are available to states for extending and improving services, not for replacing services already being rendered by private and public agencies. The American Heart Association, the U. S. Public Health Service and the U. S. Bureau of the Census are coöperating in their respective fields to help conquer this disease, which from the viewpoint of age and distribution and its total mortality and morbidity ranks among the great unsolved problems of the era.

#### RHEUMATIC FEVER IN SAN FRANCISCO

No significant statistical data are available on rheumatic heart disease in San Francisco. This disease was first made reportable in California in 1942 and 18 cases were reported in that year. In 1943, 30 cases were reported and in 1944 to date, 46 cases. These meager figures obviously do not give the true picture and their paucity is the best argument for a widely publicized and intensive rheumatic fever program.

In statistical and epidemiological studies of rheumatic heart disease in children, there appears to be marked geographic differences in the incidence of the disease. From the available information, no definite conclusions can be drawn as

to the disease being an infectious process, though the streptococcal group is generally associated with the laboratory findings, or secondary to the poverty triad of insufficient and incomplete diets, poor housing and overcrowding. Perhaps all of these are concerned in some manner.

The magnitude of the rheumatic heart as a disease problem is recognized by health officials. The statistical estimates of the death rate from heart disease in the group from 5 to 24 years is an indication of the prevalence of rheumatic heart disease. Sanatorium care for rheumatic heart disease is the most logical means of checking the severity of the infection and possible recurrences. It is also believed worthwhile to try the effect of change from cold, damp regions to warmer ones.

Specific home care for those discharged from sanatoriums is likewise deserving of special consideration. It is hoped that the medical and lay populations will come to recognize that sanatorium care is as important for rheumatic heart disease as it is for active tuberculosis.

191 Grove Street.

J. C. GEIGER,  
San Francisco.

#### Re: Medical Benevolence Funds

In the September issue of CALIFORNIA AND WESTERN MEDICINE editorial mention was made concerning the Benevolence Funds of the California Medical Association and Los Angeles County Medical Association.

The subject is one that should be of interest to many physicians. To reassure any C.M.A. members who may hold the belief that California is embarking into unknown seas, excerpts are here given from an article that appeared in the *Pennsylvania Medical Journal* (April, 1940, p. 1006):

##### *Medical Benevolence Fund of the Medical Society of the State of Pennsylvania*

The plan outlined below was inaugurated in Pennsylvania in 1905 by an allotment of 15c from the annual dues of each member of the Society. This allotment in the 35 years of the fund's history has averaged approximately 49c, and for the past 12 years has been \$1.00 annually. On Dec. 31, 1939, the fund approximated \$173,000 cash and bonds (par value).

In the wisdom of the Board of Trustees, only the contributions and the earnings from the fund are available for distribution. For many years the demand absorbed the earnings; therefore, the fund has grown and will continue to grow slowly under the allotment system unless those of our members who are financially able will contribute to it.

While it is not desirable that the benefits from this fund should at any time be looked upon as resembling the benefits operative under health, accident, or old-age insurance, the amount of money available for distribution should be sufficiently large to render real service to applicants (sick or aged) whose income is otherwise inadequate to provide the ordinary necessities of life.

The Woman's Auxiliaries of our state and county medical societies have contributed the magnificent sum of \$35,000 to the fund (total contributions \$38,500).

In the four years ending August, 1939, the fund averaged 33 beneficiaries, who received in the 48 months a total of \$37,532.

At present (in 1940) the fund has 35 beneficiaries who received a total of \$9,755 during the past 12 months, some in monthly payments, some quarterly, and some at irregular intervals according to the need.

The Committee on Benevolence, realizing the fund's inadequacy, herewith solicits subscriptions and legacies to be added to the principal. For your convenience blanks are attached. Contributions will be acknowledged through the columns of *The Pennsylvania Medical Journal*. Such contributions are recognized as proper for deduction in calculating one's annual income for tax purposes.

1 1 1

Excerpt from Article 9, Section 3, Constitution.—Each year, out of the funds of this Society, the trustees shall appropriate a sum not to exceed \$1.00 for each member, to be set aside by the Treasurer as a special fund to be known as the Medical Benevolence Fund. This fund shall be kept separate from other moneys, and may be invested by the Treasurer under the direction of the Board of Trustees, and shall be used only for the relief of pecuniary distress of sick or aged members, or the parents, widows, widowers, or children of deceased members.

Chapter 6, Section 6, By-Laws.—The Committee on Benevolence shall consist of the Secretary and 3 members to be selected annually by the trustees, at least one of whom shall be a trustee. This committee shall select its own chairman, secretary, and treasurer, and shall have absolute and confidential jurisdiction over the distribution of such part of the Medical Benevolence Fund as may be placed in its hands. No money shall be paid from its treasury except on warrant signed by the chairman and secretary of the committee, and an annual audit of its accounts shall be made by a committee of the trustees, the names of the beneficiaries being omitted. All beneficiaries shall be designated by number, and after each annual audit all communications tending to show the personality of the same shall be destroyed. This committee may solicit subscriptions, donations, and legacies to be added to the principal of the Medical Benevolence Fund. It may also receive subscriptions to be used for the relief of members in distress from the effects of any special catastrophe.

#### California State Industrial Accident Commission

Sacramento, Sept. 24.—Former Senator J. C. Garrison, who was appointed to the old State Industrial Accident Commission during the Olson administration, has raised a legal poser which has Governor Warren stumped.

Today, the Governor named five members to the new seven-member State Industrial Accident Commission.

The law creating the seven-member commission went into effect September 15. Garrison, whose term expired January 15, 1945, had not been replaced. Neither had he been reappointed. He now contends that since he was still functioning as a member of the commission when the new law became operative, he must be classified as a holdover member and continued on the new commission.

Alexander Watchman, San Francisco, also appointed during the last administration, holds a commission which does not expire until January 15, 1946, so he clearly continues in office.

The Governor has withheld action on the seventh member on the commission. He named Everett A. Corten, San Francisco, as chairman; Daniel Murphy, Jr., son of Sheriff Murphy of San Francisco; Ernest B. Webb, Long Beach, Ralph E. Mustoe and Anthony Racine of Los Angeles as commissioners. Paul Scharrenberg, who has served in the dual capacity of chairman of the commission and director of the industrial relations department, becomes director of the department solely, at salary of \$8,000 annually, instead of \$6,000 as formerly.

Corten, who has served as chief counsel for the commission, will receive \$7,500 annually, and his colleagues \$7,200.—*San Francisco Chronicle*, September 25.

America is the last abode of romance and other medieval phenomena.

—Eric Linklater, *Juan in America*.

This great spectacle of human happiness [America].

—Sydney Smith, *Essays: Waterton's Wanderings*.



## ORIGINAL ARTICLES

## Scientific and General

PSYCHOGENIC FACTORS IN OBSTETRICS  
AND GYNECOLOGY\*ROY E. FALLAS, M. D.  
*Los Angeles*

THIS symposium on Psychogenic Factors in Obstetrics and Gynecology, has been arranged in response to a specific need for information in the field of psycho-neuroses and psycho-therapy. The physician has always been aware that his medicine and surgery were often of secondary importance in affording relief to his patient. He knew that in a high percentage of his patients his intuitive understanding of their problems, their confidence in his wisdom and sympathy, and the freedom they enjoyed to disclose the hidden conflicts of their lives worked cures in some magical way.

Why has this unique patient-physician relationship been so effective as a therapeutic measure? Like so many remarkable phenomena surrounding us we have taken this particularly significant one for granted and failed to bring to bear upon it the analysis and study it deserved. The startling relief from symptoms experienced by patients after they have unburdened themselves to their confidant, the doctor, of secret unendurable conflicts, should have made us all suspect that a vital relationship of cause and effect existed in the conflict and the symptom. If we can, therefore, accept this relationship as valid, it would seem reasonable to take another step. If we can accept the theory that it is possible for a patient to suffer from conflicts unrecognized by him, of which he is completely unconscious because recognition would be too painful and disturbing we may then account for symptoms for which even the close physician-patient relationship may offer no relief.

## FREUD'S CONTRIBUTIONS

It was in this field of the unconscious conflict that Freud made his monumental contribution to human psychology. He pointed the way to a scientific instead of an intuitive understanding of the results obtained by the physician and developed a technique for the unearthing of the hidden conflict. But as so often happens in the history of science, his psychology and therapy met with profound suspicion and resistance, for he substituted science for magic; just as Holmes and Semmelweis substituted bacteriology for miasmas and faced the scorn of their colleagues.

There was a time in the history of medicine when, says Freud, "dissecting human corpses in order to discover the internal structure of the body was as much a matter for severe prohibition as practicing psycho-analysis, in order to discover the internal workings of the human mind, seems today to be a matter for condemnation."<sup>1</sup> This was written twenty-five years ago but still today in some medical circles the soundness of Freud's work is questioned. The explanation of this scepticism is perhaps that few of us are without some neurotic tendencies and that acceptance of Freud's psychology tends to make us aware of them, always a disagreeable experience. Add to this the disturbance of our profound belief in the infallibility of our chemical and physical science

and our hereditary religious and ethical concepts, and it is not too surprising that we turn with fierce resentment against this new concept which asks us to re-educate ourselves, take a new point of view and a re-orientation in medical philosophy. Oddly enough the most violent scoffer is most often the most poorly informed. He has probably never read Freud's introductory lectures, which, by the way, are examples almost without equal, of clear and logical writing capable of holding the interest of students to the end.

This lack of familiarity with a mental-therapeutic science considered by many to be as fundamental to medicine as physiology and anatomy, is however, being slowly corrected. Medical schools are incorporating psycho-analysis in their curricula and even popular magazines are bringing more and sounder information to the lay public. The war with all its trauma to minds as well as bodies has increased this interest.

These then are some of the reasons for this symposium. It is an attempt to offer some fundamental information and points of view for approach to the problems that we must all face with increasing frequency, so that we may more efficiently offer help, and perhaps cure to that large group of desperate people who wander from doctor to quack seeking a relief that can never be achieved by drug or surgery, but only by understanding.

1930 Wilshire Boulevard.

## REFERENCE

1. Sigmund Freud. *A General Introduction to Psycho-analysis.*

## PSYCHOGENIC FACTORS IN OBSTETRICS\*

FRANCES HOLMES, M. D.

*Los Angeles*

IT has become apparent that in diseases such as ulcers, asthma, and colitis, the "emotional factor" is very important, perhaps the entire etiology. Since pregnancy, labor, and the puerperium are considered "normal processes," the profound emotional changes which take place are too often overlooked or made light of. The obstetrician must deal with three situations:

1. The prolonged period of pregnancy.
2. The acute period of labor and delivery.
3. The indeterminate postpartum period.

The fact that this involves approximately one year of the patient's life is in itself significant for the development of psychological stresses. Obstetricians are becoming more aware of these factors in their patients. Since a patient may express one attitude and at the same time harbor an opposite one, we see conflicts arising. Many women consciously have no desire for children; others have unconscious aversions to pregnancy, but express conscious desires. In both cases the conflict results in a psychological and physiological reaction.

## A WOMAN'S ATTITUDE CONCERNING PREGNANCY

A woman's attitude toward pregnancy is based on early sex education, satisfactory sexual adjustment, and a desire for a child. If pregnancy occurs shortly after marriage or too soon after a previous pregnancy, in a family not financially secure, there naturally arises an antagonism towards the child and an unconscious rejection of it. The woman who does not want a child is thought to have rejected the feminine rôle. A truly normally adjusted woman does not reject pregnancy.

\* Chairman's Address. Given before the Section on Obstetrics and Gynecology, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945. One of five papers in a Symposium on Psychogenic Factors in Obstetrics and Gynecology.

\* Read before the Section on Obstetrics and Gynecology, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945. One of five papers in a Symposium on Psychogenic Factors in Obstetrics and Gynecology.

Ed. Note.—Many references were given, but not being keyed in text, are not printed.

Then there are the women in whom there is a strong selfish desire for children because it is a means of getting support or inheritance or a method of binding the husband to her.

A tragic situation is observed in unmarried women who strongly desire children. Since they can accomplish this aim only by defiance of public opinion, there arises a pronounced state of frustration. This is believed to be one of the major psychological mal-adjustments in American women.

Many obstetricians do not regard psychological influences as a factor in sterility, although there is a growing opinion among psychiatrists that unconscious wishes may be of considerable importance. It is a well known fact that if you want a sterility patient to become pregnant, have her adopt a child!

#### EMOTIONAL ATTITUDES TOWARD PREGNANCY

Once pregnancy has taken place, certain emotional stresses come into play. These will vary according to whether the child is wanted by one or both parents, or is an unwished for event. Most parents attempt to reconcile themselves, but a conscious acceptance of the inevitable does not always indicate an ability to adjust to it. The obstetrician recognizes that unconscious rejection is often expressed by excessive vomiting. The readjustment to the growing tumor that the patient must make in her social and sexual life as well as to her increasing physical unattractiveness are all important facts to keep in mind.

Many pregnant women become conscious of their heart beat, their fatigue alarms them, they are more inclined to weep, are more sensitive to remarks or criticisms; they are more critical, more exacting, more demanding. They may use their "condition" as a means of demanding more attention and love from their husband, since they fear the loss of his love because of their loss of figure. In instances when the husband and relatives' indulgences are excessive, the wife's neurotic satisfactions may be increased and with them may go a rejection of her mature rôle and even of the pregnancy itself.

Anxieties may arise due to ignorance or misconception. "Old Wives Tales" and sadistic reports of older women regarding their experiences with pregnancy are not without their effect even on the most normal women. Hirst states that all pregnant women are anxious to a degree beyond that of a normal non-pregnant woman.

#### ELEMENT OF FEAR

The meaning of pregnancy to the mother varies but some generalities are noted. In no other state is fear such a dominant factor. This fear differs in intensity and manner of expression, depending upon the personality of the mother. Superstitions and poor sex education are largely responsible. Ignorance as to the mechanism of birth may be a factor.

Fears most frequently encountered are:

1. Fear of the child being deformed, feeble minded or marked. It is interesting to note that usually the first question asked by the mother after delivery is, "Is the baby all right?"
2. Fear of death to themselves or the child.
3. Fear of sexual intercourse!
  - (a) Fear of its effect upon the husband if denied.
  - (b) Fear of its effect upon the child if permitted.
4. Fear of childbirth; such as attendant pain, lacerations.
5. Fear of getting out of shape.
6. Fear of responsibility of bringing up a child.

#### FEAR ELEMENT: ITS TREATMENT

The treatment consists:

1. Recognition of these fears and the influence that they exert.
2. Encouragement of frank expression of them by the patient.
3. Attempt of the doctor to evaluate these fears in order that the patient may adjust her attitude towards them.

A most important factor in the emotional state is whether the child is wanted or not. An illegitimate pregnancy with its social, economic, and emotional complications will set up entirely different reactions from a very much desired pregnancy. Illegitimacy is not the only situation where pregnancy is undesired. A pregnancy which occurs in spite of contraceptives and persists after measures to produce abortion, is frequently associated with bitterness and resentment, and a sense of guilt, as well as fear that the child may have been harmed by these attempts and will therefore be abnormal.

Other causes of unwanted pregnancies are economic— inability to give the child what the parents desire for it; the number of children already in the family; discomforts of previous pregnancies; fear that the marital relations will be adversely affected. In an unhappy marriage a child is usually not wanted. If the husband reacts unfavorably towards the pregnancy, this will effect the wife's attitude. The physical and social limitations imposed by pregnancy may be the cause of resentment. Having a child to improve the relations of an unhappily married couple is not advisable and does not produce healthy attitudes. Most women who do not desire a pregnancy will resign themselves to it with fairly good grace. In some, the attitude of rejection may be so deeply rooted that the obstetrician must give his full attention to it. Rejection of the pregnancy may be expressed as pernicious vomiting, or as an inability to carry out doctors' orders.

Rejection by vomiting is usually seen in the educated, intelligent girl, practically never seen in the southern negroess. Vomiting is worse in unwanted pregnancies. Neurotic individuals become increasingly so in states of pregnancy. The patient unconsciously would like to get rid of the child and because her earliest conception of pregnancy was that the baby was in the mother's stomach, she believes it possible to rid herself of it by vomiting. Later education fails to eradicate these childhood beliefs.

#### PROPHYLAXIS

Prophylaxis would be approached as follows:

1. Healthy emotional development of the child.
2. Adequate sex education especially as applied to marriage, pregnancy, and motherhood.
3. Eradication of the belief that morning sickness is an inevitable symptom of pregnancy.

#### PERNICIOUS VOMITING

Immediate Treatment of Pernicious Vomiting:

1. Isolate patient in quiet room.
2. Explain the vomiting as her emotional rejection of the pregnancy. Explain the mental mechanism previously described.

Hirst cites a case of pernicious vomiting in a 32-year-old primipara. When the vomiting first occurred, the patient's father had said to her, "You will have a bad time of it as your mother vomited the entire time she was carrying you." When her doctor explained that the vomiting was occurring only because of the suggestion from her father, and that she was now cured, she had no further attacks. Eleven months after delivery, she became pregnant again, greatly to her indignation, and vomiting became pernicious. Again Dr. Hirst saw her and felt that it was produced by a semi-conscious desire to end an unwanted pregnancy. She was told that the



vomiting would cease as soon as she made up her mind that she would have to face her problem, and go through with the pregnancy, that the vomiting would not be regarded as an excuse for terminating it. The following meal she retained, and no further difficulty was experienced.

Hirst feels that all prenicious vomiting is hysterical and curable by suggestion, that the physiological vomiting of the first weeks gives rise to the suggestion of continued vomiting which can be stopped by explanation and persuasion, without recourse to isolation, diet, drugs, which act only by suggestion. Hysterical vomiting in one pregnancy is likely to suggest a recurrence in all subsequent pregnancies.

#### PATIENT-PHYSICIAN RELATIONSHIP

An obstetrician must be aware of all the anxieties that may upset his patient and must encourage the patient to talk about them. He should truthfully explain the facts of pregnancy and delivery. It is, as a rule, unwise to show pictures which illustrate the process of child birth as this is often too realistic and will horrify rather than relieve the anxieties. It is not advisable to tell patients that they had a difficult labor or a hard delivery. This may cause the convalescent period to be prolonged and be responsible for a state of passive dependency that persists longer than is normal. The doctor too often deals with the problem by a pat on the back and a cheery word that everything will be all right. This does not allay fear. The patient must be taught to live with it. She can be convinced that this fear underlies her nervousness, sleeplessness, etc. She must be encouraged to discuss her fears. If she is told that fear is a natural accompaniment of pregnancy, she will have a minimum of symptoms.

It is most important that the doctor know the patient's personality and her "way of experiencing." It is common knowledge that the same event has different significance for different individuals. The event assumes whatever meaning the patient places on it herself. The patient's concept of herself in relation to the world must be noted:

Does she submit passively to the environment, being buffeted about by it, or does she value herself above everything else, considering the world as something to be dominated by her?

Will she consider her pregnancy as an encroachment of the world on herself, or will she experience it as an aggrandizement of her already extensive ego-valuation? Will she submit to it or rebel against it?

Consideration must be given to the way the patient experiences herself in relation to her body. Does she become alarmed at the occurrence of normal phenomena or does she minimize events of possible pathological significance? With this knowledge, the patient helps the doctor to evaluate her symptoms such as dizziness, heart burn, etc., that she will complain of.

#### PATIENT'S ATTITUDE TOWARDS LABOR

The patient's attitude towards *labor* must be considered. There is a wide variation in sensitivity to pain. With the months of discomfort preceding delivery, labor is not a dreaded ordeal, but rather a promise of release from a burden. Rarely is it such a traumatic experience that the mother develops hostilities towards her child, or feels that she can never be repaid for her suffering.

The effect of emotions on labor is to be considered. The nature of the contractions may be affected by unconscious emotional factors. The patient, during her antepartum period, should be conditioned to minimize the discomforts of labor.

#### POSTPARTUM PERIOD

Fortunately for most women, the nine months of pregnancy is a happy experience, but with the postpartum

period, a new set of trials begin. The *child* now becomes the center of attention, rather than the mother, who becomes the servant for the child. She finds that she now has a hard job. The acceptance of the maternal rôle is largely determined by her emotional maturity and stability. Her success is greatly determined by the husband's attitude to the new arrival in the family. It is in the postpartum period that the more serious emotional complications develop. The change from being a pregnant woman who received a great deal of attention from her entire family, to the state of being a mother where the attention and care is directed to the baby, and she is expected to resume her former status, plus the added responsibility of the child, certainly carries with it many emotional changes. The restriction of social activities, the problem of fitting a new member into the family without causing jealousy from the other children is often difficult.

#### PERSONALITY CHANGES

Symptomatology is often manifest in sexual matters such as antagonism towards husband, distaste for sexual relations, abnormal sexual behavior; or as amnesia of the birth, belief that the child is dead or is not her own, or as actual attempts to kill it.

The earliest symptoms of a beginning psychosis is that of personality change. Frequently it is observed as general discontent, increasing tension, excessive anxiety, insomnia, and irritableness.

The emotional instability which so often accompanies pregnancy must be recognized by the obstetrician and treated to prevent its further development into a more serious emotional state. The handling of such matters must be by the doctor and not by well meaning friends whose advice is tainted with superstitions, fantasies, and fears. The period of pregnancy is not an easy one emotionally as the patient is bombarded with advice and information, usually of a morbid nature concerning herself and her unborn child. Since every woman is temperamentally different, it follows that no two pregnant women can be handled in the same way. When nervous tensions are noted, obstetrician must take the time to talk over whatever problems are present. He must know when to ask leading questions, how to provide the release for tears that are just beneath the surface. When he makes light of her worries, she will keep them to herself and they can assume tremendous proportions. The prenatal build-up period must include the emotions as well as the physical—sympathy and understanding must be the doctor's attitude toward the patient, and frankness even to the point of offensiveness should be his attitude toward a family which is inclined to keep the patient agitated by a morbid atmosphere.

#### SUMMARY

In an obstetrical practice, one sees a cross section of life, birth, death, hope, eager anticipation, growth of a sense of responsibility, despair, tragedy, and comedy.

This is a plea to the doctor to try to understand what underlies the anxieties so often seen in pregnancy and to give wholesome mental food throughout pregnancy, labor, and the puerperium.

3780 Wilshire Boulevard.

America is a country of young men.

—Emerson, *Society and Solitude: Old Age*.

Some hae meat and canna eat,  
And some wad eat that want it;  
But we hae meat and we can eat,  
And sae the Lord be thankit.

—Robert Burns, *The Selkirk Grace*.

## PSYCHOGENIC FACTORS IN GYNECOLOGY\*

GEORGE E. JUDD, M. D.  
*Los Angeles*

THE origin and derivation of the word hysteria, which means the wandering of the uterus, serves to impress us with the long recognized relationship between disorders of the genital tract and psychological disturbances.

### HISTORICAL

A review of the historical background goes back to Hippocrates and Galen whose writings and ideas were dominated by the feeling that diseased genital organs were the underlying cause of many manifestations of hysterical disturbances.

This idea of the adverse effect of genital pathology upon the psyche was embraced and carried along by medical men through most of the 19th century—and as late as 1893 it was taught that "It is preëminently diseases of the hysteria, of the uterus and its adnexae, which lead to the most pronounced and most frequent symptoms of hysteria."<sup>1</sup>

In the late eighties anomalies of position, ulceration of the cervix and chronic metritis were considered the underlying pathology of hysteria.

There developed a reversal of this viewpoint at the turn of the century by epoch making works of Bleuler, Freud, Breuer and Janet.<sup>2</sup> They called attention to the psychic aspect of many functional disturbances and ailments. This was particularly applicable to internal medicine, although resistance to the idea by the leaders of gynecology was felt then and still is for that matter.

Kroenig in 1902<sup>3</sup> stressed the importance of functional nervous disorders in gynecological diagnosis and therapy. He recognized as purely psychogenic certain hyperesthesias of the genitalia. He emphasized the frequent occurrence of psychogenic pruritis vulvae and mentioned psychogenic sensation of prolapse without prolapse.

As a result of this new conception of symptom production many discussions in gynecological societies occurred, the consensus of opinion was that although many favored the psychogenesis of genital disorders the majority did not think that disturbances could be caused solely by psychic processes. They rationalized that the symptoms produced in the absence of pathology were due to changes in the central or peripheral nerves that were as yet not recognized.

Bossi and Schultze<sup>3</sup> as late as 1912 attempted to prove that diseases of the genital organs in the female were essential etiological factors in mental disturbance, even insanity and suicide.

Siemerling and Walthard, among others, were early leaders who recognized the fact that psychiatry had come into its own in gynecology and general medicine and not that gynecology had taken up an abode in psychiatry.

Walthard separated the cases with psychogenic disturbances and treated this group with psychotherapy—this consisted almost entirely of suggestion. By the time World War I came along many men observed and confirmed the fact that marked psychic traumata and chronic disturbed emotional states produced marked effects upon the menstrual function.

A. Mayer, Director of the University Women's Clinic of Tübingen<sup>4</sup> said that "many of our patients present gynecological symptoms without being sick gynecologically. Their illness is a psychic conflict sailing under

a gynecological flag, a fact that has not escaped the attention of the quacks."

Grafenberg, 1929,<sup>5</sup> says, "It has become more and more a matter of course for the gynecologist to take psychic factors into consideration in evaluating the symptoms of women."

### PURPOSE OF ARTICLE

This statement expresses briefly the purpose back of this paper; to more or less call attention to the problems of the personality and emotions that may be etiological factors in the symptom picture that is presented to us as gynecologists. Much criticism has been leveled at the specialist for focusing his attention upon his own particular anatomical field without knowing much of the remainder of the body, but even more the short period of observation allows no information about the background of the patient's personality. This knowledge of the patient, her development and family that was so well known by the general practitioner or the old "family doctor," in so many cases enabled him to treat with keen insight many symptom complexes in ways that flaunted the scientific knowledge of pharmacology and pathology.

We may readily ask them what symptoms could psychic factors prove to have etiological influence.

### DYSMENORRHEA

The first condition that comes to mind that is recognized today to have psychogenic factors in its production is dysmenorrhea. This common gynecological complaint has long been recognized as being influenced by the attitude of the patient towards the presence of the menstrual flow. J. Novak and Harnik<sup>6</sup> reported 247 cases of dysmenorrhea where psychic traumata was indicated as the inciting cause of the symptom—with the use of psychotherapy directed towards the recovery of the memory of the trauma and with reassurance as to the underlying cause, was followed by complete relief of 62 per cent, partial relief in 34 per cent—failure in 4 per cent.

Hypnotic control of dysmenorrhea was reported to be very successful by Margaret Brennan of the Menninger Clinic.<sup>7</sup>

The treatment of primary dysmenorrhea in modern text books of gynecology call attention to psychogenic factors of its production. They call attention to the fact that many times painful periods are found in emotionally high strung and often unstable girls and many of them call attention to the development of the pain some months or years after the initiation of the menstrual flow.

The relief of pain following a sympathetic explanation with reassurance by the gynecologist has proved to be a value and has established the fact that psychogenic factors are present in dysmenorrhea.

### FRIGIDITY

The next most common complaint coming to the gynecologist where it is clearly recognized that psychogenic factors exist in its etiological background is, frigidity. Robert P. Knight in the Bulletin of the Menninger Clinic<sup>8</sup> reports the fact that 75 per cent of women derive little or no pleasure from the sexual act. He feels that prejudice, revulsions, anxieties referable to menstruation, pregnancy, childbirth, intercourse, lactation, child training are pertinent factors in the sexual anesthesia. He says many of these feelings and attitudes stem from older women both in and out of the family.

The treatment of this condition, even though the gynecologist is often the "father confessor" to many of his patients, has been taken over by the psychiatrist, psychologist or psychoanalyst. The gynecologist is relegated usually to treating only those conditions in which anatomical factors may mechanically interfere.

\* Read before the Section on Obstetrics and Gynecology, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945. One of five papers in a Symposium on Psychogenic Factors in Obstetrics and Gynecology.



There is not much question of psychogenic factors in these two conditions—what about other symptoms. The triad of bleeding, pain and leucorrhea has been called the daily bread of the gynecologist.

#### AMENORRHEA

The question of bleeding brings up metro and menorrhagia as well as amenorrhea. To begin with amenorrhea is not infrequently the result of episodes of emotional stress. R. Schindler, 1927,<sup>9</sup> reported a number of war amenorrheas. This was found in well nourished, robust women. The condition often disappeared with the return of the husband on leave.

Kohnstamm and Forel<sup>2</sup> induced periods of amenorrhea up to several months with hypnosis.

The amenorrhea of pseudocyesis is too well known to require any additional proof that emotional states can cause the cessation of menstrual flow for several months.

#### METRO-MENORRHAGIA

What about metro- and menorrhagia? J. Novak and M. Harnik,<sup>10</sup> in 1929, reported 45 cases of psychogenic bleeding describing three of them in detail. In all the cases but one it was possible to elicit an episode of psychic trauma leading to the bleeding. Most of the patients had been unsuccessfully treated with medications. Psychotherapy of a superficial sort brought about relief. In one case it was cured by hypnosis.

Julius A. Miller<sup>11</sup> reported in detail six case histories of metro- and menorrhagia in patients of varying age that were treated successfully by psychotherapy. In one case the symptoms had been present for three years. The rôle of fear of pregnancy and coitus recurred in the psychic conflicts in five of the six cases.

In the psychotic patient there is much evidence showing the association of irregularity of menstrual flow with excessive flow often encountered:

We may tread on dangerous ground in this gynecological symptom if we assume that irregular bleeding in a neurotic woman is psychogenic in origin—to be sure cancer can develop in the emotional maladjusted as well as any other. Diagnostic curettage and biopsy are imperative in all cases where irregular bleeding indicates the chance of cancer.

Psychotherapy however may offer an avenue of approach to clinical relief in the case where cancer has been adequately ruled out, and where endocrine therapy has been unsuccessful, in the case where the obvious neurosis of the patient may make a major surgical procedure unwise.

#### PAIN

In a discussion of pelvic pain and its psychogenic factors, there are some embarrassing cases that I can call to mind from among my patients. These cases are the ones operated upon for painful pelvic lesions—where minimal findings and maximum discomfort were present and in which relief from other means such as rest, heat and other forms of palliative treatment had failed to bring relief. The discrepancies between pelvic pain and the magnitude or extent of pelvic pathology has been called to our attention in the text book discussions of endometriosis.<sup>12</sup>

My first acquaintance with the possibility of psychogenic aspects in pelvic pain occurred with the following case.

#### REPORT OF CASE

CASE 1.—This patient, age 33, married 11 years was seen for right sided, sharp, intermittent abdominal pain that was definitely increased by activity. It had been present for two years and she, at one time previously, had been hospitalized for the possibility of an acute ap-

pendix. Her menstrual periods began at the usual age, were slightly irregular in occurrence with some irregularity as to the amount of menstrual flow. There had been one pregnancy six years previously which had ended in an induced abortion which she freely admitted was due to the fear of delivery. The blood count varied on several occasions from 8,000 to 11,000, the sedimentation was normal. This patient was observed for four months during which time she was studied thoroughly by an internist and had had one hospital admission with a complete gastro-intestinal x-ray. Other than hypermotility of the intestinal tract there were no suggestive findings. During this time the patient was definitely incapacitated because of the pain and finally, after consultation with another gynecologist, there was a feeling that a minimal lesion of endometriosis or inflammatory disease was present in the pelvis to account for the pain. A laparotomy was done after a curettage, both tubes were normal and both ovaries appeared to be perfectly normal. There were two small fibroids in the anterior wall of the uterus approximately 2 cms. The culdesac was free from adhesions although there was a very small lesion about ½ cm. in diameter that had a suggestive umbilication of endometriosis in the left utero sacro ligament. A hysterectomy was done, the area of the left utero-sacro ligament was resected. The pathological report stated two fibro myomata but no evidence of endometriosis in the resected portion of the uterus. The patient made a satisfactory recovery although she was extremely nervous and agitated and very despondent. Five weeks following the laparotomy the agitation and depression had increased to the point of where the patient was put in a sanitarium because of an abortive attempt at suicide.

*Comment.*—I am certain that the complaints of this patient would have been much better handled by early psychiatric attention rather than gynecological surgery even though every attempt was made to be sure of our ground prior to surgery. Consultants who had been called into the case were sincere in their belief that the condition was due to physical changes and at no time was there any attempt to promote the indication for surgical procedure.

The question of pain production has always brought up the question of the threshold of preception—the combination of minimal findings with well established pelvic pain should encourage at least some search into the anxieties of a patient to determine if they may intensify the symptoms of the minimal lesions.

#### LEUCORRHEA

The literature is particularly rich in reports of the association of leucorrhea of psychogenic origin. O. Bunemann,<sup>13</sup> in 1921, reviewed a number of cases of leucorrhea cured by suggestive therapy. In one case he reported, 12 years of local treatment without relief. To convince himself of the origin in this one case he brought back the symptom of hypnotic suggestion after the patient had been relieved for a year and then eliminated it again by the same means.

Walther, Sellheim and Lowenstein all have reported series of cases of leucorrhea of psychogenic origin. The diverse psychic factors often so closely preceded the appearance of the discharge that the association was very close.

In 1929, at the German Gynecological Congress when leucorrhea as a symptom was discussed in detail the psychogenic component in the etiology was definitely admitted.

A recent incident among my patients shows some suggestive association.

#### REPORT OF CASE

CASE 2.—A young woman, was seen for a trichomonas vaginitis that had been treated for eighteen months at more or less frequent intervals, with periodic recurrence, by one or more gynecologists. She decided to again change gynecologists because the last treatments had been very painful and came under my observation.

During a six month period no trichomonas were found although from time to time a profuse and annoying

leucorrhea would recur at sharply defined intervals—she was asked to remember when these occurred and to pay attention to the incidents that preceded the appearance of the discharge. The next time she returned to the office she related that her mother who lived with her had for years caused trouble in her home—the patient objected particularly to her mother's scolding of her older son and had arranged for him to be away much of the time. On the preceding weekend when the boy was home a particularly heated scene developed between the patient and her mother, during the height of it she noticed the sudden appearance of a large quantity of mucous although she had been free from it prior to that time and had no evidence of discharge when seen a few days later. She was firmly convinced of the association of the discharge with the unpleasantness in her household and has been entirely free from trouble since.

A. Mayer,<sup>4</sup> in discussing the origin of this symptom, gave the following explanation—"Unconscious sexual ideas are as likely to lead to hyperemia and hypersecretion in the genital region as are conscious ideas, the physiological effect of which is well known."

The pruritis vulvae group furnish additional association of psychogenic factors in gynecology. There are many cases on record of relief by psychotherapy that had defied all other means.

During the past year, five cases have been treated by breaking up the vicious cycle of the scratching and by having the unsatisfactory sex life of the patient treated by a psychologist. With all cases the question of masturbation, both conscious and unconscious was discovered.

#### REPORT OF CASE

CASE 3.—The last case gave the history of a frigid marriage; a circumcision of the clitoris, and three years of estrogenic therapy hypodermically and locally. The admission of masturbation during this period with an intense feeling of guilt and the fear that it was producing severe local injury to her were elicited. Progress is being made in clearing up a most distressing symptom picture by psychotherapeutic means under the direction of a competent psychiatrist.

#### DISCUSSION

The foregoing discussion does not furnish absolute proof that these often-seen gynecological complaints are entirely due to psychogenic factors. To disregard the personality problems of the patient or to fail to take into account the neurotic accentuation of any symptom picture where neurosis exists will continue to show discrepancies between pathology and symptom picture.

A plea is made to include into routine history taking the simple questions that show attitudes of the patient towards many of the problems of adjustment to normal living. Greater emphasis should be placed on marriage relationship and attitude towards pregnancy, coitus, contraceptives, etc. In spite of the fact that a one-hour interview has distinct limitations and that the later interviews may alter or completely change the initial impression, the estimation of the incidence of the neuroses in the makeup of the patient will go a long way towards putting a proper value upon the symptom picture and help correlate the findings. It is well to keep in mind that psychiatric consultation prior to surgery may prevent the needless or often poorly timed laparotomy.

It is well to appreciate that a psychiatric consultant is being placed in many large and progressive gynecologic clinics for the purpose of studying the personality backgrounds of patients and to help correlate the symptom picture with the clinical and pathological findings.

Objections have been raised and rightly so against psychotherapeutic treatment by the doctor who treats organic ills as well. It is often impossible because of limitation of time to do much for the neurotic patient. This fact however does not justify the indifference of the clinician to the emotional aspect or the psychogenic factors either as a cause of symptom production or as a

factor in accentuation of symptoms that may be produced by minimal pathology.

Max Mayer of the Mt. Sinai Clinic<sup>14</sup> has presented a sound idea when he reasons that these cases are not either organic or psychic problems, but often a combination of both. He says the psychiatrist or psychoanalyst "can give sympathy, support, and a point of orientation; can tend to modify the environment, if necessary with the assistance of social service; can assist in the acceptance of reality; can try to remove or alleviate anxiety; can build up general resistance, strengthen the ego to compensate for frustrations, and can use the various forms of symptomatic and suggestive therapy in cases that do not lend themselves for obvious reasons to formal psychotherapy. Such suggestive therapy is used in conjunction with the use of local treatment such as pessaries, hydrotherapy," etc.

Mayer, in his timely article, based upon his work at the Mt. Sinai Clinic, came to the following conclusions why gynecologists should know some psychotherapy.

1. To be able to elicit a psychanamnesis.
2. To avoid certain difficulties in the case management of sick women.
3. To know when to supplement his gynecologic therapy with psychotherapy.
4. To use the latter prophylactically, as in premarital instruction.
5. To understand the dynamics of many of his medical and surgical cures.
6. To know when and where not to recommend formal psychotherapy such as analysis.
7. To know when to avoid the subject.
8. To know more about himself.

#### SUMMARY

1. There is developing in the literature a growing evidence of psychogenic factors in the etiology of many gynecological complaints.
2. Frigidity and dysmenorrhea have well recognized psychogenic factors in their etiology.
3. The triad of bleeding, pain and leucorrhea may have psychogenic factors that either produce or accentuate the symptom.
4. A plea is made to include into routine history taking, questions that will bring insight into possible emotional conflicts of the patients.
5. Much work will be necessary in the future to bring clarity and understanding in the field of symptom production, where psychiatry and gynecology meet and in many cases overlap.

1930 Wilshire Boulevard.

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## NEUROSSES OF WAR WIVES\*

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WHEN Congress declared the existence of a state of war, and then, in its infinite wisdom, determined that babies born before September 15, 1941, were conceived prior to Pearl Harbor, it inaugurated a series of manifestations which, for want of a better term, may be called "War Neuroses." It is our purpose here to examine these neuroses insofar as they affect the pregnant woman, and to consider how their effects may be mitigated.

Even a cursory study makes clear that these phenomena are not new. They are entirely analogous to the humor of the broadcasting booth, in which old jokes with a new "twist" hide the fact that there are no new stories. Similarly, the neuroses observed during a time of war are merely the same well-known hob-goblins with different scenery. It cannot be denied, however, that a number of shy neuroses, emboldened by novel surroundings, have appeared to strut upon the stage in the hope that they will be considered new starlets in the firmament of phantasy.

## INITIAL MANIFESTATIONS

To consider "war neuroses" in a somewhat chronological order, return, please, to the edict of Congress that would separate the sheep from the goats as of September 15, 1941. How many of you were importuned, backed up with tears if necessary, to induce labor when that event seemed dilatory? In extreme instances, the need for a child by the dead-line date was thought to be so great that premature labor was demanded, regardless of risk, lest a frail young mother be forced to curtail her expenditures in a manner to which she had no intention of becoming accustomed, the Fates and an obstetrician willing. Previous speakers have detailed some of the vague symptomatology presented by mentally-disturbed individuals who chance to be pregnant. I venture that none of these were missed in this group. Late vomiting, extreme heartburn, attacks of faintness, intractable constipation, and all the other complaints of the constitutionally-inferior individual were paraded forth. Staunch indeed was the accoucheur who maintained his balance in such emotional storms.

Possibly next in order should be mentioned the wife of the ideal of America, the I-A man. How many of you were asked to certify that a newly-pregnant wife, with "pernicious" vomiting at the moment, needed the presence of her husband to carry her by a critical stage in her history? And how often did the vomiting recur as the period of grace granted by an impressed Local Board neared an end? Or, if pregnancy were near term, how many of you requested deferment until after the delivery date, and then were asked to certify that the well-being of the freshly-fledged mother would be jeopardized if the husband were inducted?

## "NORMALCY" OF PREGNANT WOMEN

The point may well be raised that these are but evidences that, irrespective of the need for racial improvement, pregnancies occur in neurotics. This is unquestionably true. Like the rain, which falls alike upon the just and the unjust, "blessed events" are no respectors of persons or personalities. If undue emphasis here is laid upon the unfit, it is because these constitute the group

under discussion. Years ago, in lectures to nurses, I used to say that the pregnant female was not a normal person, *if she ever was*. For the past few years, I have begun to wonder if what was remarked in a cynical mood was not closer to fact than had been appreciated.

## EMOTIONAL REACTIONS IN SERVICE WIVES

Previous speakers have adequately discussed the emotional attitudes toward pregnancy. Again to recount these may seem repetitious, but is unavoidable to some extent. Pregnancies occurring in a group of service wives entail not only the mental disturbances ordinarily encountered, but also a number due primarily to the disruption of the home. Consider the psychical strain of an unwanted pregnancy in a young woman whose family life has been interrupted. The absence of her husband, who probably has been the stabilizing influence in her life, serves to exaggerate her fancied symptoms. Vomiting will be prolonged and excessive, and the accepted treatments prove of no avail. Years ago the late Whitridge Williams employed a régime of inserting dulled needles under the breasts of chronically vomiting girls, and then over-distending the submammary tissues with salt solution under considerable pressure. The treatment was brutal, but seldom had to be repeated. As he expressed it in his pithy fashion, "It gives them something else to think about, and they are afraid to vomit." To resort to such drastic measures cannot be advocated, but if the attendant bears in mind the basis for over-complaining he may be able to give the patient "something else to think about," even if he cannot entirely eliminate the underlying emotional conflicts.

## ON CHANGES IN FAMILY RELATIONSHIPS

Quite a few difficulties arise entirely from the changes in family relationships caused by the war. One of these concerns the desire for a child as a replacement for the lost companionship of the husband. Unless pregnancy is secured promptly, the wife appears in the physicians' offices demanding investigation and results. Too often there is but little one can do for these poor frustrated souls. They cannot bring themselves to accept the facts placed before them. One will carefully outline the procedures contemplated over a period of months, and the response will be "How much of this can we get done this week?" Their very urgency militates against success. A single finding deemed by them as unsatisfactory and they betake themselves elsewhere. Torn and tormented by denied hopes, they live from month to month, from camp to camp, and from doctor to doctor.

## STERILITY

Sterility is a problem that is extreme in its complexity. Its study should include a careful urological survey of the male side of the question, and with the husband at a basic training center or out on maneuvers, the possibility of securing such information is much reduced. Not all urologists care to undertake these investigations. When the urologist available to the serviceman is possibly some one assigned to that division and without any real qualifications, the reported findings lack in detail and in reliability. The ovulatory phase in the wife's menstrual cycle will seldom coincide with the husband's occasional leaves from camp. Above all is the increasing tension. Next month may be too late. What can be done must be done at once or sooner. In the mind of the wife, she has already received the dreaded wire from the War Department, and with the expected orders for overseas duty, she mentally goes into premature mourning.

In 1942 the Pacific Coast Society of Obstetrics and Gynecology held a symposium on "Obstetrics as Affected by War Conditions." In that discussion, T. Henshaw Kelly of San Francisco, remarked that "the theme-song

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of the girl of today seems to be 'Please Give Me Something to Remember You By.' The song is out of date; the idea still prevails.

#### FINANCIAL FACTORS

Reduction in family finances oftentimes has entailed real financial hardships and is frequently advanced as a reason for avoiding pregnancies. Many service wives find it necessary or convenient to work while the customary provider can supply but \$50.00 per month. Under these circumstances, a pregnancy is regarded as a catastrophe of the first magnitude, and the fear that such might occur results in a pronounced change in marital relationships, with, of course, alterations in subconscious attitudes evident even to one not versed in the psychiatrists' vocabulary. The attempt by the Federal government to provide free attentions for maternity is only a partial solution and has provoked other disturbances as will be mentioned later.

#### ON ABSENCE OF HUSBAND

Whether because labor is one of the greatest achievements in a woman's life, or because she has been impressed by the warnings of her sadistic friends, a woman usually wishes her husband at hand while she passes through the valley of the shadow. The certainty that he will not be present arouses resentments in some, self-pity in others, fears and phobias in still another group. Quiet counseling by the obstetrician will do much to comfort these girls. An explanation as to what labor really is, and as to how the patient can help herself, frequently will give her a more joyful approach to motherhood.

#### EMERGENCIES—ACTUAL VS. UNREAL

A rather frequent bit of misinformation given out by well-meaning friends is the suggestion to the service wife that if the doctor will but send a wire stating that her condition is critical, the Red Cross will get her husband to her in rapid order. *In an emergency*, the Red Cross will do exactly that. It will cut red tape, establish travel priorities, advance funds, and perform a whole host of needful services with a minimum of lost motion. *But—*an emergency must first exist, and when the doctor explains that he cannot produce an emergency to order, as it were, the disappointment that this will not be done is tremendous. Oftentimes the wife comes to feel that her physician, in whom she needs to trust implicitly, is lacking in sympathetic understanding of her peculiar problems. Here again, careful and complete explanation is helpful in readjusting the accord so necessary between patient and physician.

#### ILLEGITIMATE PREGNANCIES

A series of emotional conflicts, fortunately encountered infrequently, is based upon fear that the husband may return to find his wife pregnant from extramarital experiences. Illegitimate pregnancy is a problem that has existed since the institution of marriage was established. It is based upon a variety of economic, sociologic and educational factors, and war, as such, has but minor significance. Indeed, save in the conquest and rape of subjugated peoples, it is difficult to postulate that war conditions affect the potentiality of illegitimacy. The one factor which influences the *actual* incidence of illegitimacy is that of opportunity. The girl or woman of a promiscuous frame of mind retains her promiscuity in spite of all restrictions. During war, restrictions are lessened, and opportunities are more easily created. Once the glamour of the moment has subsided, and the unwelcome fact becomes apparent that pregnancy has resulted, there are pronounced psychical disturbances. Usually these are characterized by resentments and antagonisms. The hus-

band is blamed for not being at hand to protect the honor of his wife. The government is blamed for taking the husband from his rightful sphere. The errant lover is blamed for having taken advantage of a situation, and for his freedom from responsibility for his crime against womanhood. Finally, the doctor is blamed for his refusal to commit a further crime, abortion, a step which the wife feels is fully justified. It seems specious to point out that the energy and time given in trying to assist these women in a readjustment of their attitudes is largely wasted.

#### SERVICE WIFE FIXATION

One further attitude of the service wife deserves particular mention, and that is the resentment that she *IS* a service wife. She feels that she is considered a charity patient. For that reason, she is convinced that things happen to her that do not occur with others in her condition. If her physician is detained in the delivery rooms and is late in meeting her appointment, it is because he doesn't mind inconveniencing her. If her analgesia fails to meet her expectations, it is because the nurses are callous to her suffering. She has built up the idea that the war has taken her home life from her, and that she is being sacrificed on the altar of Mars. No matter what happens, every ache and pain and discomfort is a further sacrifice required of her and her alone.

#### RESENTMENTS PROVOKED BY CHILDREN'S BUREAU PUBLICITY

In mentioning the conflicts arising from a fear of pregnancy because of financial status, the rôle of the Federal Government was noted. You are, no doubt, familiar with the E.M.I.C. program. Wives of service men of the lowest four grades are assured, in numerous publicity items from the Children's Bureau, that the costs of maternity will be paid by the government. It is emphasized that the eligible wife may go to the obstetrical attendant of her choice. She is not informed that many physicians refuse participation in the program on the principle that no agency should stand between the patient and her doctor; that others, particularly in the larger centers, find the permitted fee too far below their actual costs to allow them to enter into such practice; and that still others, including many over-worked general practitioners, are entirely too busy caring for their own clientele to accept any and all applicants. If she has remained at home, she has as a rule no difficulty in securing attentions from those who normally would be consulted were her husband out of uniform. It is the transient patient, following her husband from place to place, whose efforts to find needed services are oftentimes unsuccessful for the reasons noted above. Her resentment is aroused by being denied the type of care promised her by the Bureau. Usually her resentment is directed against the medical profession, a fact which becomes of more importance in view of the prominence of the question of governmental regulation of medicine.

#### SEMI-PSYCHIATRIC TENDENCIES AMONG SERVICE WIVES

Unfortunately, the frequency with which service wives present semi-psychiatric tendencies makes such patients even less desirable. The conscientious physician finds that they average more time per visit than his other patients. The financial loss entailed is of much less importance to many than is the loss of time. Even the Santa Claus Children's Bureau, which cheerfully gives away our services, cannot provide us more than twenty-four hours a day.

#### DISEASE AND "DISORDERS"

The end result, then, is that we are not properly caring



for the mental maladjustments of our patients, whether service wives or not. For headache, we suggest empirin if aspirin has been used, and aspirin if the patient has been taking empirin. Various barbiturates are relied upon to relieve sleeplessness. We are treating symptoms only, and the canker continues to fester below the level of our consciousness. We understand disease better than we do disorders. Until and unless we take the time necessary to apply the teachings of our psychologist and psychiatrist confreres, we will continue to be of little real help to those of our patients who suffer from fears, phobias and fantasies.

#### THINGS TO REMEMBER

One fact stands out clearly. The uncertainties under which service wives carry on their lives breeds further unrest in their minds and souls. They cannot know where next month or even tomorrow may find them. The search for quarters is always arduous and sometimes impossible. They live under strains that we civilians can only guess, and their fortitude, rather than the occasional imbalance that here we emphasize, is most remarkable. If occasionally they lapse from accepted behavior, we should never forget that "battle fatigue" is encountered also on the home front.

Equitable Building.

### THE SIGNIFICANCE OF PSYCHOANALYSIS FOR GYNECOLOGY\*

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THE papers just presented in this symposium amply demonstrated the significance of psychogenic emotional factors in gynecology and obstetrics. It cannot be otherwise, since, to quote Dr. Holmes, "In an obstetrical practice, one sees a cross-section of life; birth and death, hope and despair—comedy and tragedy"—. And the gynecological practice deals, I might say, with the essence of life—with love. The gynecologist is called upon to help women sustain or restore their capacity to love—to be happy and to make others happy. The gynecologist is the custodian of the female reproductive organ system, the normality of which guarantees normal wives, normal mothers, happy marriages and normal children.

Viewing gynecology in this wide perspective, the specialist is faced with the necessity to take psychogenic factors into consideration, not only for an understanding of the pathogenesis of the gynecological syndrome, but also for the indications of his therapeutic approach.

I know that the good specialist has always been a good doctor in general. He has never forgotten that in many cases it is not only the special organ system of his patient which requires care—that behind the ear and the eye, the nose and the throat—and behind the uterus, there is a human being, who suffers.

#### HOW PSYCHOANALYSIS HAS HELPED

Before Freud and before psychoanalysis, the doctor who tried to help his patient by appealing to the emotional part of his personality, had as his tools only his good will and his intuition. Through psychoanalysis the physician has gained scientific knowledge about the psychodynamics of the personality because psychoanalysis disclosed to him the realm of the unconscious, the source of instincts and human passion. All psychopathological phenomena, such as neuroses, psychoses, functional organ disturbances originate in the unconscious strata of the

human mind. Freud made the unconscious amenable to a scientific understanding and to the physicians' therapeutic endeavor.

For experimental proof of the fact that unconscious ideas influence and alter bodily functions, we need not look only to psychoanalysis. Hypnotic experiments furnish sufficient evidence. Let me cite one such experiment. You cannot persuade an individual to alter his skin texture by his conscious volition, but if you hypnotize the person and plant into his unconscious the suggestive idea that he has burned his finger, he will develop a typical blister.

#### AUTHOR'S PURPOSE

Doctors Judd and Holmes frequently alluded to the fact that disturbances of the functioning of the female reproductive organ system must come about through interferences of *unconscious* ideas which are in contradiction to the conscious wishes and ideals of the individual. They as well as many other physicians employ a psychoanalytic concept in their psychotherapeutic approach. Thus it is apparent that psychoanalysis is of great significance for an understanding as well as for the treatment of psychogenic factors in gynecological syndromes. It is my task to present some of the psychoanalytic theories and experiences in order to demonstrate *why* psychoanalysis deserves an important place in the armament of your specialty.

I might preface my remarks by warning you that as far as emotional factors in gynecology are concerned, I may place as much or even more weight on the significance of hate than of love in the psychopathogenesis of gynecological disorders. For there are two instincts which determine human emotional life—the sex instinct with its mental manifestation of love, and its antagonist, called by Freud the death-instinct, with its emotional representative of hatred. It is very often unconscious ideas of hatred which interfere with the individual's capacity to love, disintegrating the physiological functioning of the reproductive organ system.

#### PSYCHOSOMATIC MEDICINE

Let me first say a few words about psychosomatic medicine in general. It is the latest and most comprehensive branch of modern medicine, which concerns the dynamic interrelationship between bodily functions and mental processes. Psychosomatic medicine tends to provide us with an objective approach by which we can understand and influence bodily functions by psychotherapy or influence mental processes by organotherapy. The autonomic nervous system administers the affect dynamics and economics of our mental system. Thus, in association with subcortical brain centers and the interrelated endocrine glands, it furnishes the physiological apparatus interacting between brain cortex and outer motor nervous system, that is, between impulse and action or between inner mental life and external reality.

What is the significance of psychoanalysis for psychosomatic medicine? There is no psychosomatic medicine *without* psychoanalysis because there was no scientific psychosomatic medicine *before* psychoanalysis.

#### MEDICAL PSYCHOLOGY

Scientific medical psychology factually came into being through Freud's psychoanalytic discoveries, this for various reasons: 1) through psychoanalysis we learned to understand symptomatic disturbances of organ functions as manifestations of a disturbance of the personality as a whole; 2) in disclosing the nature of the hysterical conversion symptom, Freud found that the ego sends energies into the innervations of inner organ systems, which have been diverted from outer motor dis-

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charges; 3) mental processes are responsible for this shift from outer motor innervations, from action impulses to inner motor innervations, into the organ system; 4) these mental processes reflect *mental conflicts*, which impel the individual to abstain from certain actions although his instinct drives are in need of an affectual discharge; 5) these mental processes, representing conflicts, occur *unconsciously* and are beyond our conscious control.

The conscious ego decides our actions. But our conscious volition is not free; it is determined by processes in the unconscious which, under certain conditions, exert their influence on the ego and might compel it to abstain from action—to withhold certain nervous energies from outer motor discharge and instead canalize them via the autonomous nervous system into bodily functions or, as Freud phrased it, "to bring about an alteration of a part of our body instead of altering a part of our surrounding world."

The great significance of this discovery is that it is inner unsolvable conflicts with an external object or with our inner conscience which cause the ego to shift outer motor action impulses into its "inner motility" and that these conflicts must occur unconsciously in order to create pathological disturbances in the organism. The treatment is based on the possibility of making an individual conscious of such conflicts and in this way to refer them back where they belong—to shift them from the soma to the mind. The possibility of a permanent or temporary cure depends on the degree to which the patient becomes capable of solving his conflicts on a conscious level. Psychoanalytic treatment gives back to his ego conscious control over his action impulses. It is then up to his insight and judgment to act them out and to change a part of his surrounding world instead of a "part of his body"—or by abstaining from acting out in conformity with his conscience, to sublimate his undischarged instinctual affect energies.

The impulses which are able to bring us into conflict with the object of our environmental world emanate from the sources of two main instincts, as mentioned before—the sex instinct and the destructive instincts. The sex instinct is the biological source of the affect of love in its broadest sense; the destructive instinct is the source of the affect of hate. Since the instinct is originated in our soma but manifests its drive in our mind, the study and knowledge concerning instinctual drives gives us the opportunity proper to study the interrelationship between mind and body, which is psychosomatic medicine.

#### MENTAL DEFENSE MECHANISM

Before I apply these general remarks on psychoanalysis and psychosomatic medicine to gynecology, I must ask your indulgence for dwelling on a specific psychoanalytic phenomenon which Freud calls "mental defense mechanism."

The ego of an individual who is entangled in unsolvable mental conflicts must defend itself against anxieties resulting from the inner perception of damned up dangerous instinctual drives. In order to keep itself adapted to the demands of reality, the ego employs various mechanisms of defense. Of particular importance for the understanding of psychosomatic phenomena is the defense mechanism of *repression*.

Repression, in psychoanalytic terms, signifies banning from the conscious part of the ego every thought which is too painful to bear and every instinctual drive, the gratification of which might bring us into dangerous conflicts. Repression, in the psychoanalytic sense, means that these ideas descend into the unconscious part of our mind and in this way are prevented from gaining access to the outer motor center of our brain cortex. The ego defends

itself against its dangerous action impulses by shutting off from consciousness the ideational content of its instinctual desires. However, the conflict does not cease to exist—it merely becomes introverted, and then, from the unconscious strata of the mind, tends to release the affect charge of repressed ideas and instinct wishes beyond conscious perception.

As we know, every affect has its physiological as well as its psychological manifestations. For example, the mental perception of anxiety is associated with a deepening of respiration and an acceleration of the heart beat. Besides, discharge phenomena like outbursts of perspiration or diarrhoea often help to diminish the mental tension aroused by the affect. What we have learned from psychoanalysis is that an individual may experience such alterations of organ functionings without being aware of his anxiety, because the ideas pertaining to this affect are hidden in his unconscious. He may then believe that he is suffering from a heart condition or from tuberculosis, because of his frequent perspiring, or from a gastro-intestinal disease, whereas he is really suffering from an unconscious emotional anxiety tension, due to an inhibited discharge of instinct energies into the outer world of objects. It is important that the gynecologist take such conditions into consideration. For the unconscious anxiety affect may seek a somatic outlet not only through biological pathways, such as those mentioned, but may also take advantage of organic discharge possibilities which present themselves under certain conditions. I know from personal observations, that profuse leucorrhoea or menorrhagia can be physical equivalents of latent anxiety tensions.

We see that under the condition of repressed unconscious affect laden ideas organ functions may have to serve two masters: they must fulfill their physiological task for the sake of the entire organism, and at the same time they must take care of a surplus of mental affectual energies which cannot find an adequate discharge either by their inner somatic biological mechanisms or by actions.

Moreover, the unconscious selection of organs for the placement of repressed instinctual drives is not fortuitous. It is basically determined by repressed, unconscious wish phantasies and often associated with infantile irrational concepts of bodily functions. The alimentary system, e.g., might be disturbed in its functioning because its biological task is interfered with by an unconscious wish to experience a gastro-intestinal impregnation. Thus the alimentary system starts dysfunctioning—it becomes "hysterical" and develops an organ neurosis.

#### UNCONSCIOUS WISH PHANTASIES

Irrational phantasies against impregnation through the mouth were developed at a time in childhood when the immature child had neither a correct concept of himself nor of his environment, i.e., of reality. When the child is unable to adequately satisfy his instinctual needs from the outside world, he substitutes actual gratification through imagination and indulges in phantasies which deny a frustrating reality.

In these phantasies the child tends to satisfy his unrequited love and his unsatiated hatred. Certain of these infantile phantasies are typical and correspond to certain stages of infantile sexuality. Since they have been originated in unsolvable infantile conflicts with the environment, the child repressed their ideational content into the unconscious, where they may remain stored up, laden with instinct affectual energies which interfere with the healthy maturing of the personality.

#### DEVELOPMENT OF MENTAL MATURING

In the developmental process of mental maturing, the child must acquire the difficult capacity to love by sub-



limiting his innate tendency to hate and destroy in reaction to love frustrations. Love is the emotional representative of the sex instinct. But the sexual instinct does not manifest itself primarily in puberty—in puberty it only becomes capable of serving the biological aim of reproduction, through the maturing of the gonade glands. The sex instinct is operative from the very beginning of life and manifests itself in pleasurable sensations, which the infant derives from the various organ zones of its body. The infant drinks milk not only because he is hungry, but also because he gains pleasurable oral sensations, and in addition feels secure in being taken care of. Likewise, the child gains rectal pleasure in emptying his bowels, as well as at times keeping back the feces. Baby care, such as diapering, drying, powdering, all give him pleasurable sensations. Eventually the infant discovers his genitals and playing with them gives him pleasurable sensations too. Out of the summation of pleasurable sensations derived from the various erotogenic organ zones, the child eventually discovers his mental ego and loves himself. This happy autoerotic or narcissistic existence, as we call it, is very soon disturbed by the fact that in the fourth year of life, the child develops sexual differentiations in his love striving and directs them toward the parents—the boy is obsessed by strong sexual demands toward his mother. Wanting to possess her completely, he conceives of his father and siblings as rivals. The little girl falls in love with her father and conceives of her mother as her rival. Wish phantasies of hate and destruction of the parent of the same sex come up and cause anxieties and feelings of guilt. Most children at this period also wish to reproduce babies with the parent of the opposite sex, without knowing how to accomplish this.

This typical infantile conflict through which everyone passes is the so-called Oedipus conflict. It would be beyond the scope of this paper to show you how we normally overcome this difficult conflict of our childhood, when our first genuine sexual desire requires a complete renunciation. Today we are interested only in the pathological after-effects of this Oedipus conflict, the effects of its incomplete repression in the unconscious, where it remains alive as an Oedipus complex.

#### PSYCHOSEXUAL DEVELOPMENT OF THE FEMALE

Since we are dealing with the psychopathological problems of gynecology, our interest is solely focused on the psychosexual development of the female. The psychosexual development of the girl is beset with *specific* psychobiological difficulties which create a disposition to failures in the mental or physical development to mature womanhood.

Before the time when the little girl falls in love with her father, she goes through a period when she dislikes her own sex and would like to be a boy. This period is called the *phallic phase* of development. During this time, the infantile sexuality of the girl is restricted to sensations from the clitoris. Clitoris sexuality is of active driving character—i.e., male quality. Vaginal eroticism, which is of passive receptive female quality develops fully only in puberty and very often is actually established through the first sexual intercourse. It is at her phallic period that the girl suffers from *penis* envy and has the idea that nature, or rather, her parents, particularly the mother, have cheated her. The boy has a penis which he proudly displays and with which he can actively direct his stream of urine. He is taught by his mother how to touch and handle his penis for such purposes. The little girl is forbidden to touch her genitals, or even to know that a genital source for pleasurable sensations exists.

The little girl feels herself castrated, and develops phantasies of comfort that some time in the future she

too may grow a penis. This phantasy of being a *ca'least*, in boy is especially intense and traumatic if the girl actually, as happens not seldom, was exposed to a castratory threat. For instance, she might have overheard her little brother being threatened with castration for masturbating. To her it is then logical that she is a castrated *boy* is especially intense and traumatic if the girl actually, clitoris. At this early age, gynecological examinations have a particularly traumatic effect, because to the little girl these examinations are a punishment and a confirmation of her fear that she is damaged for life. Penis envy and hate against men as penis bearers assumes enormous proportions when the parents indulge in the glorification of the boy as their male offspring or, as happens not so seldom, even tell the little girl how disappointed they were when she was born, because what they wanted was a boy.

#### INFLUENCE OF NEUROSES OF PARENTS

Of particularly traumatic influence to the psychosexual development of the girl are the neuroses of the parents, which precipitate neurotic complexes in their children. A mother who never solved her own masculinity conflict and has never accepted her feminine rôle might perhaps react by denying her daughter all sexual information, or might misinform her by telling her that intercourse is disappointing or disgusting, "men are beasts in sex." The father, still unconsciously fixated toward his own mother, might have developed a sexual taboo toward his wife when she became a mother and unconsciously transfers his latent incestuous feelings to his daughter as a mother-substitute. Without realizing it himself, he may overstimulate his daughter's infantile sexuality by too much affection, by too much caressing.

The girl who has not been exposed to such traumatic influences, can develop normally. This implies that, strange as it seems, penis envy is transformed into the wish for a baby. It is as though the possession of a penis loses its significance when and if the little girl gives up her phallic sexuality through replacing the heretofore leading erotogenic zone of the clitoris by the interior of the vagina. With the maturing of the gonade glands, the normal desire for intercourse, for pleasurable reception of the partner's penis and *for conception*, dethrones the wish for possessing a penis.

The brief sketchy outline I have presented about the psychosexual development of the girl does not reflect any theories, but is based on facts which the psychoanalyst uncovers again and again in the psychoanalysis of neurotic women. During the psychoanalytic treatment of psychoneurotic women, we encounter various kinds of gynecological symptoms which manifest their disturbed psychosexuality, organ symptoms which disappear when their unconscious meaning has been revealed.

#### DISTURBANCES OF THE FEMALE PSYCHOPHYSICAL PERSONALITY

Let me select a few manifestations of the disturbance of the female psychophysical personality. The most comprehensive disturbance is based on the fact that a woman has remained fixated or arrested in her psychosexual development at the phallic phase of her childhood. She repudiates totally or partially her own sex—her feminine rôle. Such women might substitute the wish for the possession of a penis by a general change of character. They develop masculine characteristics in their behavior and engage in all kinds of activities which are considered masculine. To phallic women, all biological manifestations of their sex are often perceived by them as an offense to their ego. They react to menstruation with depression or anger and rage. Every genital bleeding seems to their unconscious that the vagina is an open

charges; because their penis was cut off. In particular, the shift from menstruation is a mental trauma, because it seems to confirm castration as a punishment for infantile masturbation. Women with a castration complex are afraid of bleeding, that they will bleed to death in defloration or in giving birth to a baby.

The unconscious mental resistance against accepting femininity, partially or totally, is very often the psychogenetic causative factor behind dysmenorrhagia. Painful abdominal cramps are often substitutes for unconscious pangs of conscience, signifying self punishment or, as mentioned previously, they may be just physical equivalents for hidden infantile anxieties. You can understand that in such cases it is important not only to alleviate the pain or stop the bleeding, which reflects the vain attempt of the organism to restore its psychophysical equilibrium—it is also necessary to bring the anxiety out in the open and to treat the unconscious mental conflict behind it.

Disturbances in the act of cohabitation are very often manifestations of unconscious aggressive castrative tendencies against the penis of the partner. Phallic women do not like intercourse. They consider the male organ disgusting. They are afraid of it, but they really fear their own destructive reaction against the penis. Disturbance of the orgasmic function, frigidity, and vaginism are likewise, in most cases, defenses against unconscious infantile incestuous wishes or often against the wish to destroy the man's penis. Anaesthesia of the vagina is an inner denial of pleasurable sensation from intercourse because of unconscious guilt feeling. The husband might still have the unconscious significance of the father and therefore intercourse with him is not allowed to yield pleasurable sensations.

In other cases, this inner inhibition of the pleasurable sensation is necessary because such women are *unconsciously afraid of an orgasm*. In an orgasm she might lose conscious control over her instinct strivings and might turn love into hate and destroy her partner's penis. *Vaginism* signifies a compromise solution of such an unconscious antagonistic attitude against the hatefully desired penis. The spastic contraction of the vaginal muscles has the meaning to capture the penis, but this is prevented because the spastic contraction of the vaginal muscles occurs as soon as the penis approaches the vagina, thus preventing the penis from entering and suffering castration.

The most common and general solution for these problems is found in the character of hysterical women, who love men, love their husbands, love the male body, but exclude the penis from any sexual desire. They might submit to intercourse for the sake of the husband, but they themselves do not require any sexual gratification.

#### ORGANIC DYSFUNCTIONS

The knowledge of these organic dysfunctions, caused by psychopathological unconscious mental processes, is of utmost importance to the gynecologist. It might indicate to him not only what he should do in some cases, but more what he should not do. I think the gynecologist, in knowing the unconscious mental background of the phenomena described, would abstain from teaching husbands techniques in intercourse, such as irritating the clitoris for the sake of an orgasm. He would abstain from circumcizing the clitoris to make it more sensitive, and he would abstain from diagnosing difficulties the husband might have in entering the vagina as due to an "infantile too small vagina" of his wife and from artificial dilatations of the vagina. Of course, he might succeed in making cohabitation more satisfactory to both partners, which is of great practical significance, but he must also be aware that he did not eliminate the patho-

genic unconscious mental source of the phenomena in question. The significance of treating the psychogenetic factors as early as possible, beyond the immediate aim of making cohabitation satisfactory rests on the fact that the unconscious mental complex might manifest itself later on, when the woman becomes pregnant, when she must deliver and take care of her baby.

The repudiation of femininity may manifest itself then in an unconscious repudiation of pregnancy. Continuous uncontrollable vomiting during pregnancy is very often an unconscious wish to get rid of the baby. Behind this wish is the unconscious infantile phantasy that the impregnation has come about through biting off and swallowing the penis. The equation has remained in the unconscious that the penis equals the baby. The unconscious phantasy that the baby developed in the stomach and must be discharged through defecation might disturb the act of delivery. The uterus as well as the vagina may suffer from constipation and develops a tendency to hold the baby back instead of giving it to the husband.

If you don't believe that such phantasies are created in childhood, I will tell you a little story. The three and a half year old daughter of a friend of mine developed a painful constipation for a number of days. Nothing seemed to help. The constipation set in a few weeks after her mother had given birth to a little brother. The girl once sat on the potty and was urgently asked by her father, who promised her candies, to deliver the stool. Finally, under abdominal cramps, she cried out in tears, "I do not want the baby to come out." Thus this little girl identified herself with her mother and had conceived the pregnant mother's big stomach as a container for the baby, and the act of delivery as an act of defecation. In a magic way, by taking over the rôle of the mother, she wanted to annul the birth of the brother, of whom she was jealous because he attracted too much love and attention and probably because he had a penis.

Spontaneous abortions during pregnancy may have their origins in unsolved unconscious conflicts. As far back as twenty-five years ago, I observed such a case in my practice. A woman who consciously had the ardent wish to have a baby, was stricken with profuse hemorrhages in the fourth month of her pregnancy. The gynecologist considered a surgical interruption of pregnancy indicated. I was called in as a consultant by the husband, who had studied some of Freud's writings. From a few dreams, I could show the patient that she was suffering from an unsolved conflict with her father. She was an only daughter, to whom the father was very much attached. His fixation evidenced itself in his behavior—he did not want her to marry and when she finally married against his wish, he reacted with deep depression and cursed her, wishing that at least she should never have a baby. The conscious digestion of this part of her father fixation and father conflict was instrumental in stopping the bleeding and enabling the woman the normal delivery of a boy.

Strangely enough, the excessive wish for motherhood—"the cry for a baby"—is sometimes determined by just the opposite wish, by the unconscious wish to be a man. Such ladies "protest too much." For them having a baby means unconsciously acquiring the husband's penis. They overcompensate and keep repressed the latent inherent wish for masculinity by overemphasizing the wish for motherhood.

One of my women patients could never understand why her husband reacted in such a hostile way to her when she announced to him that she was pregnant. In analysis, she remembered the wording of her communication. She phrased it: "Now, I don't need you any longer—I am pregnant." Psychoanalysis revealed that the unconscious meaning of her statement was: "Now I don't need your



penis any longer, because I have it inside of me and will produce it in the form of a baby."

The unconscious masculinity complex of women is a very common cause of unhappy marriages and broken homes. These women instead of living in coöperation with their husbands, compete with them. They begrudge him his work, his success. Instead of considering themselves the inspiration for his success, they feel that they have been relegated merely to the rôle of a servant, who must do the dirty house work and care for his daily needs. What such women actually do not know is that they have never overcome their infantile frustration of not being the man themselves. Many times they accuse the husband of not satisfying them sexually, without realizing that they themselves may be the cause, because of their frigidity.

It might be considered a healthy compromise if wives with such complexes develop their own individual professional career, independent of the husband, and leave the care of their household and children in someone else's hands.

There is no doubt that *after* giving birth to a baby the woman's attitude might also be determined by unconscious emotional factors. Their own ambivalence conflict of love and hate toward the husband and his masculinity, is sometimes transferred onto the baby. Such mothers are often afraid of baby care and particularly fear having to nurse the baby. Without being aware of it, they are afraid of their babies, afraid of what the babies can do to them. They project onto the baby their own unconscious hostility. Such ambivalence conflicts within the mother may have physical consequences for the baby, and also for the mother herself. They may lead to cessation or stagnation of the secretion of the mammary glands.

Let me give you an example. The young mother who announced that she did not need her husband any more because she was pregnant, fell sick during the first months of lactation with an extended infectious mastitis. Through nursing, the baby became infected and developed a general furunculosis. This not only deprived the baby of his mother's milk once and for all, but also made several surgical operations necessary for the mother, and for the baby. In psychoanalysis the woman remembered how she might have brought about her mastitis. Whenever the baby was brought to her to be fed, she could not help feeling afraid, so that she pulled away from him, while he fed at her breast. The baby lost the nipple and had to find it again. This little fight between the baby's mouth and the mother's nipple could be rightly held responsible for the erosions which, by way of infection, developed into an abscess.

Every obstetrician and pediatrician knows that the physiological process of lactation itself is influenced by conscious emotional upsets. There is no doubt that unconscious complexes, as described before, can likewise interfere with its successful functioning. An *unconscious* psychogenic influence on the activities of the mammary glands was once strikingly brought home to me when I psychoanalyzed a hysterical frigid woman, with a strong wish for motherhood. Once she dreamed that I was her baby—the baby she wished from her father—and that she nursed me. She awoke from her dream with some secretions from her nipples.

It seems mysterious, but it is an undoubted fact, as Dr. Holmes mentioned in her presentation, that fertility and sterility are also conditioned by unconscious mental influences. Psychoanalytic treatment of sterile women has proved that they become capable of conceiving after their unconscious conflicts have been made amenable to conscious mental digestion. The strange phenomenon that a supposedly sterile woman becomes fertile after adopting

a baby has been explained by psychoanalysis, at least, in one case.

Orr\* reports the detailed psychoanalytic case history of such a woman. It is as though her ego was capable of giving up her unconscious resistance and self-denial for motherhood only after she had been allowed to accept motherhood first without the procedure of her own cohabitation and impregnation, which was taboo, because of unconscious infantile conflicts. It is the unconscious wish for virginal conception by excluding the male partner, which must have found its realization first.

#### ON USE OF PSYCHOANALYTIC KNOWLEDGE BY THE GYNECOLOGIST

I hope that despite the sketchiness of my presentation, I have said enough to demonstrate *why* psychoanalysis is of great significance for gynecology and obstetrics. The gynecologist might now ask how he can employ his psychoanalytic knowledge in his practice. It is not easy to give a satisfactory answer. Certainly the gynecologist cannot subject his patients to a regular psychoanalytic treatment. Even if he were to have adequate training, he could not devote enough of his time to such treatments. However, by virtue of his psychoanalytic knowledge, he will be in a much better position to fulfill the tasks of his specialty.

He will be able to focus his interest on the total psycho-physical personality of his woman patient. In taking her history, he will be interested not only in the history of her preceding organ diseases but also in her life history, particularly that of her psychosexual development. He will inquire about her childhood, about her sex education. From this material he will be able to form an opinion about the libidinal constitution of his patient, whether she is emotionally well balanced or whether she lives, as Freud phrased it, "beyond her mental means." The latter implies that without being aware of it herself, she suffers from frustrations either because of her own inhibition or because of her partner's incompatibility.

The sleep of such women is disturbed, particularly the phase of sleep after intercourse. After normal satisfactory cohabitation, the individual is completely relaxed and sleeps well; after unsatisfactory sexual relations, the sleep is disturbed by anxiety dreams, very often manifesting more or less symbolically disguised aggressions against the partner. Above all, the gynecologist must ascertain whether his patient is entangled in an actual conflict. If this is so, he will sometimes find that the patient's symptoms are a means of escape from an unbearable reality and fulfill a certain task. The patient avoids mental agony by feeling sick and unconsciously uses her suffering to neutralize her latent guilt feeling and very often as a defense weapon against her undesired partner. As an example, I mention menorrhagia, occurring whenever the husband demands intercourse, which the woman tends to avoid out of suppressed guilt feelings, perhaps because of her erotic interest in another man.

The few illustrations I gave you may suffice to show that a thorough knowledge of psychoanalysis will enable the gynecologist to arrive at what we call a *psychodynamic diagnosis* of his patient's total personality. Such a diagnosis provides him with indications for his therapeutic approach. If he discovers that the patient's organ disturbances are localized manifestations of a general psychoneurosis, he will refer her for treatment to the psychoanalytically trained psychiatrist, at the same time keeping her physical condition under observation. If he concludes that the patient's symptom is a physical reaction to an unbearable situation, he might apply psycho-

\* Orr, Douglass W.: *Pregnancy Following the Decision to Adopt*. *Psychosomatic Med.*: 3:441-446 (Oct.), 1941.

therapy himself, if he has the necessary psychoanalytic knowledge.

This psychotherapy in the office of the gynecologist can benefit a great number of patients because psychosomatic disorders are fortunately often not caused by deeply *repressed unconscious* complexes but precipitated by thought and affect material which is only *preconscious*. Thought material is termed *preconscious* when it is *suppressed* and shifted away only temporarily from the conscious perception of an ego which is unable to understand or interpret a specific conflict situation.

You will be astonished at the number of women, who only because they lack knowledge about what I might call the psychological facts of life, react with organ disturbances to the tasks of womanhood. Their emotional reactions to actual conflicts with the parents or the partner are suppressed, due to a lack of intellectual understanding or the incapacity to verbalize their impressions. Such patients get relief from their physical symptoms if they are made to understand their own and their partner's organ functionings, and provided with the adequate verbal concepts to vent their pent up emotions.

Even in cases where the gynecologist can help the patient to understand and digest her conflict, only insofar as it is the conscious end of a deeper unconscious conflict, he might at least alleviate her organ symptoms. What the gynecologist does here is to demask the psychological meaning of a somatic symptom, so that the organ can no longer be misused for mental economic purposes. The psychoanalytically oriented physician will talk relatively little himself in such psychotherapeutic interviews. He will rather be the listener. Of course the most important and most difficult task for the gynecologist is to decide when to stop his psychotherapeutic approach or refrain completely from psychotherapy, because his patient needs the care of the psychoanalytic specialist.

I cannot accept the usual objection that the busy physician does not have time for such psychotherapy. It is true he must set aside a number of appointments for such patients outside of his office hours, appointments which may last one hour each. By doing this, however, he may save himself and his patient many weeks or months which otherwise would have been used for organ treatments. He might even spare his patient the prospect of becoming a life long gynecological patient. For there are women who become libidinally fixated to their doctors and produce or cling to symptoms because the gynecological treatment itself provides them with a latent gratification for unconscious instinctual needs.

I am convinced that in the future, when psychoanalytic knowledge has become an integral part of medical training, there will be a change in the method of medical practice. At the present time the daily schedule of the doctor is divided between office hours, home calls, surgery and other hospital work. In the same way as the doctor now sets aside more time for surgery than for patients seen during office hours, so in the future will he introduce another sub-division into his schedule, this for psychotherapy.

#### IN CONCLUSION

In conclusion, I might say that the gynecologist, in his special field of psychosomatic medicine needs psychoanalytic knowledge in order to understand the manifestations of the unconscious in his patients. With this knowledge, he will be aware of how often the body is an instrument of the mind and that the body speaks an organ language, which conveys a message from the unconscious ego of the patient to her conscious ego. By understanding this message, even if he does not translate it to the patient, the gynecologist gains a new perspective for his indications and a new stimulus for his therapeutic endeavor.

555 Wilcox Avenue.

#### Cost of Battleship for Research in Medicine

No one is concerned about the cost in dollars of the American fleet that recently pounded the Japs into submission. Whatever the cost, we deem it worthwhile. Battleships at 75 million dollars each are a bargain for what they accomplished.

But with the war ended, it is time to ask ourselves an old question, which I have placed before readers on a number of occasions in the last decade: When will we be willing to spend the price of a battleship on the conquest of cancer?

In his report to President Truman on postwar scientific research, Dr. Vannevar Bush proposes a program of medical research that is big but still would cost us less than a new battleship a year.

He would begin the program of medical research for the nation with an appropriation of five million dollars a year, stepping this up to about 20 million dollars a year in time.

His feeling is that such research would best be carried on in the medical schools and research institutions now in existence and that appropriation of money ought not to be more rapid than the possibilities of putting it to work.

In other words, money by itself does not bring results. The money is effective only to the extent that trained scientists are on hand to utilize the funds.

As President Roosevelt observed when he asked Dr. Bush to undertake the present report last November, one or two diseases cause more deaths a year in America than have been suffered by this nation in World War II.

Heading the list of killers in America is the group of diseases resulting from high blood pressure and hardening of the arteries, namely, heart disease, and cerebral hemorrhage. This group causes one-third of all the deaths in America.

In 1940, there were 536,745 deaths from diseases of the heart and arteries. The amount spent on research in this field in 1940 was \$94,000 or 17c per death.

This situation would be dealt with by the recommendations proposed by Dr. Bush. He proposes, however, that the researches be carried on in existing institutions rather than in new Government laboratories.

"The primary place for medical research is in the medical schools and universities," he writes in his report. "In some cases coordinated direct attack on special problems may be made by teams of investigators, supplementing similar attacks carried on by the Army, Navy, Public Health Service and other organizations.

"Apart from teaching, however, the primary obligation of the medical schools and universities is to continue the traditional functions of such institutions, namely, to provide the individual worker with an opportunity for free, untrammelled study of nature, in the directions and by the methods suggested by his interests, curiosity and imagination. The history of medical science teaches clearly the supreme importance of affording the prepared mind complete freedom for the exercise of initiative."—David Dietz, in *San Francisco News*.

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Henry David Thoreau (1817-1862).—Thoreau made pencils and taught school for a living. He was a friend of Emerson and a member of the famous Concord circle. His reputation as a naturalist rests on his immortal "Walden." Undoubtedly, if he had spent less time outdoors, he would have succumbed sooner to the tuberculosis to which he was subject. While counting growth rings on old tree stumps during a wet snow storm, he contracted a chill and the tuberculosis became active. In a vain effort to regain health, he went to Minnesota, but died in his forty-sixth year.—Warner's *Calendar of Medical History*.



# CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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## OFFICIAL NOTICE

### COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

#### Minutes of the Three Hundred Twenty-eighth (328th) Meeting of the Council of the California Medical Association

The meeting was called to order in the Empire Room of the Hotel Fairmont in San Francisco, at 10:30 A.M., on Sunday, August 21, 1945.

#### 1. Roll Call:

Councilors Present: Philip K. Gilman, Chairman; Sam J. McClendon, E. Vincent Askey, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, Walter S. Cherry, Edwin L. Bruck, E. Earl Moody, Dewey R. Powell, Edward B. Dewey, and George H. Kress, Secretary.

Councilors Absent: Sidney J. Shipman.

Present by Invitation: L. A. Alesen, M.D., Vice-Speaker; Dwight H. Murray, M.D., Chairman, Committee on Public Policy and Legislation; Chester L. Cooley, M.D., Secretary-Treasurer, California Physicians' Service; J. Frank Doughty, M.D., Chairman, Special Committee to report on Association of American Physicians and Surgeons of Indiana; Mr. Fred Kraft, Assemblyman from San Diego; John Hunton, Executive Secretary; W. M. Bowman, Executive Director, California Physicians' Service; Hartley F. Peart, Legal Counsel; Howard Hassard, Associate Legal Counsel; Clem Whitaker, Public Relations Adviser; James J. Boyle, Chief of Washington Office of the United Public Health League; Ben H. Read, Secretary, California Public Health League; Stanley K. Cochems, Executive Secretary, Los Angeles County Medical Association; Rollen Waterson, Executive Secretary, Alameda County Medical Association; W. Glenn Ebersole, C.M.A. Special Representative.

#### 2. Minutes:

Minutes of the following meetings of the Council and Executive Committee were submitted and actions taken approved:

(a) Council Meeting (324th) held in Los Angeles, May 5, 1945. (Printed in C. & W. M., June, 1945, page 344.)

(b) Council Meeting (325th) held in Los Angeles, May 6, 1945. (Printed in C. & W. M., June, 1945, page 347.)

(c) Council Meeting (326th) held in Los Angeles, May 7, 1945. (Printed in C. & W. M., June, 1945, page 347.)

(d) Council Meeting (327th) held in Los Angeles, May 7, 1945. (Printed in C. & W. M., June, 1945, page 347.)

(e) Executive Committee Meeting (192nd) held in Los Angeles, May 7, 1945. (Printed in C. & W. M., June, 1945, page 348.)

(f) Executive Committee Meeting (193rd) (Telephone intercommunication with mail vote ratification). (Printed in C. & W. M., August, 1945, page 82.)

† For complete roster of officers, see advertising pages 2, 4, and 6.

\* Reports referred to in the minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

(g) Executive Committee Meeting (194th) (Telephone intercommunication with mail vote ratification).

(Printed in C. & W. M., August, 1945, page 82.)

Concerning the action taken at the 194th meeting of the C.M.A. Executive Committee, Chairman Gilman gave the reasons why it seemed desirable to cooperate with neighboring constituent state medical associations in order to further the promotion of California Physicians' Service and of principles which had received approval by the C.M.A.

(h) "Trustees of C.M.A." Meeting (17th) held in Los Angeles, May 7, 1945. (Printed in C. & W. M., June, 1945, page 348.)

(i) Directors of "Trustees of C.M.A." Meeting (41st) held in Los Angeles, May 7, 1945.

(Printed in C. & W. M., June, 1945, page 348.)

### 3. Membership:

(a) A report of the membership as of August 11, 1945, was submitted and placed on file. The membership roster showed distribution as follows:

Total members (civilian and military) listed for year 1945: 7,790.

Total members in military service: 2,252.

(b) On motion made and seconded, it was voted to reinstate 90 members whose 1945 dues had been paid subsequent to the last meeting of the Council on May 7, 1945.

(c) On motion made and seconded, Retired Membership was granted to the following members, whose applications had been received in accredited form from their county societies:

Charles Morton Hosmer, San Diego County,  
Barney E. Coleman, Los Angeles County,  
J. F. Garrison, Los Angeles County.

### 4. Financial:

(a) A cash report as of August 11, 1945, was submitted.

In the discussion of the cash report, reference was made to the moneys in the Benevolence Fund. Councilor Anderson called attention to the fact that the Benevolence Fund had been increased in considerable amount through donations from the Woman's Auxiliary to the California Medical Association. It was voted that a letter be sent to the Woman's Auxiliary expressing appreciation for the generous donations that have been made to the Benevolence Fund.

(b) Report was made concerning income and expenditures for July and for seven months, ending on July 31, 1945.

(c) A balance sheet, as of July 31, 1945, was submitted.

On motion made and seconded, the above reports were received and placed on file.

### 5. Interim Appointments:

The following interim appointments made by the Council Chairman since the last meeting of the Council on May 7, 1945, were approved:

(a) Alvin G. Foord, Pasadena, appointed a member of the Professional Advisory Committee to the Bureau of Vocational Rehabilitation.

(b) William G. Donald, Berkeley, appointed a member of the C.P.S. Study Committee, vice H. J. Templeton, Oakland, resigned.

### 6. A.M.A. Meeting in San Francisco in 1948:

Discussion was had concerning the meeting of the American Medical Association which, by vote of the A.M.A. House of Delegates, is scheduled to be held in San Francisco some time during the year 1946. Because of war and transportation conditions, it was deemed advisable to give instructions to the C.M.A. delegates who

would represent the California Medical Association at the next meeting of the House of Delegates of the American Medical Association.

On motion made and seconded, the following resolution, to be sent to the Trustees of the American Medical Association and to the House of Delegates of the American Medical Association, was approved:

Resolution re: Meeting of American Medical Association in San Francisco

WHEREAS, The House of Delegates of the American Medical Association in previous annual sessions voted to hold an annual session of the American Medical Association in San Francisco in the year 1943, that decision, because of transportation difficulties incident to World War II, being changed by the A.M.A. Trustees; and

WHEREAS, The A.M.A. House of Delegates subsequently voted that the 1946 annual session of the American Medical Association should be held in San Francisco; and

WHEREAS, Existing transportation difficulties, if war continues, make it more than probable that the A.M.A. Trustees may again be called upon to waive the said decision for the A.M.A. meeting in San Francisco in 1946; and

WHEREAS, The 1947 meeting of the American Medical Association will be held in Atlantic City, the year 1947 being the 100th anniversary of the founding of the American Medical Association; and

WHEREAS, It would be proper that the twice-made decision of the House of Delegates to hold an annual session of the American Medical Association in San Francisco be reaffirmed; now therefore be it

*Resolved*, That the Council of the California Medical Association respectively petitions the Trustees of the American Medical Association and the House of Delegates of the American Medical Association to vote to hold the 1948 annual session of the American Medical Association in the City of San Francisco, (if continuation of World War II makes a meeting in San Francisco impossible); and be it further

*Resolved*, That copies of these resolutions be sent to the Secretary of the American Medical Association for transmittal respectively to the Trustees of the A.M.A. and the House of Delegates of the A.M.A.; and be it further

*Resolved*, That the eight delegates representing the California Medical Association in the House of Delegates of the American Medical Association be instructed to make the proper presentation to the A.M.A. Trustees and to the A.M.A. House of Delegates.

(b) Doctor Dwight H. Murray, Chairman of the Committee on Public Policy and Legislation, referred to the meeting held some months ago in Portland by the A.M.A. Council on Medical Service and Public Relations. He stated that it had been intended to have a meeting soon thereafter in California, but owing to the work incident to the legislative session, it had been postponed.

Upon motion made and seconded, it was voted to invite the A.M.A. Council on Medical Service and Public Relations to hold such a meeting in California in the near future.

### 7. Annual Dues for 1946:

A letter of June 15, 1945, from the Shasta-Trinity Medical Society was presented as follows:

"This Society disapproves of the House of Delegates in raising the annual dues of the California Medical Association to one hundred dollars for any or all of the reasons advanced by the Council whose recommendation it was."

It was voted that the Shasta-Trinity Medical Society be informed that the action taken was by the House of



Delegates of the California Medical Association which has supreme authority in such matters and that the Council was not in position to change the same.

#### 8. C.M.A. Committee to Report Re: Association of American Physicians and Surgeons:

The special committee appointed in accord with Resolution No. 4 (printed in C. & W. M., for June, 1945, on pages 328 and 340), presented at the C.M.A. Annual Session in May, 1945, to consider the objectives of the Association of American Physicians and Surgeons, made report. The committee consists of J. Frank Doughty, Tracy, Chairman; H. Gordon MacLean, Oakland; G. Dan Delprat, San Francisco; H. Randall Madeley, Vallejo; Samuel Ayres, Jr., Los Angeles; Eugene F. Hoffman, Los Angeles; K. C. Brandenburg, Long Beach; W. H. Geistveit, Jr., San Diego; H.M.F. Behneman, Healdsburg.

An oral statement was made by Doctor Doughty concerning the meetings that had been held by the committee. The report of the Special Committee is as follows:

"Re: Association of American Physicians and Surgeons

"The special committee appointed by the Speaker of the House of Delegates, unanimously adopted the following report which is presented herewith:

"In the opinion of this committee the objectives of the A.A.P.S. while highly commendable are capable of achievement by the California Medical Association without the necessity for additional organizational activity.

"Continuous diligence on the part of the California Medical Association in meeting the dangers of extraneous control of medical practice is urged."

Upon motion made and seconded, the Council voted to accept and approve the report as submitted.

#### 9. American Cancer Society:

Lyell C. Kinney, M.D., Chairman of the C.M.A. Cancer Commission submitted a report on correspondence and conferences with representatives of the American Cancer Society concerning cancer clinics, and other cancer activities in California. Attention was called to the House of Delegates resolution concerning cancer clinics (printed in C. & W. M., for June, 1945, on page 336).

Reports submitted by the Cancer Commission were approved as follows:

August 11, 1945.

The Council of the California Medical Association,  
Gentlemen:

Recent correspondence with the American Cancer Society has developed several important facts regarding the so-called "prevention clinics." The American Cancer Society has not formally approved any prevention clinic in California and has received no formal request for such approval. It is the policy of that Society not to approve any clinic unless it has the approval and supervision of the county medical society, or unless it is approved by the state executive committee. It is feasible now, if you so direct, that the executive committee shall be so formed that it reflects the will and judgment of this Council.

The American Cancer Society recognizes that many new clinics have been formed throughout the country that have no uniform or consistent policy and that there are no established standards for the operation of these clinics. In order to remove this confusion in its own policy, the American Cancer Society has referred the problem of clinics to a group of five well known and distinguished physicians. These are:

Dr. Frank E. Adair, Chairman  
Dr. Edwin P. Lehman  
Dr. John J. Morton  
Dr. Eugene P. Pendergrass  
Dr. Herman C. Pitts

In order to further clarify the situation, the American

Cancer Society has approached the Council on Medical Service and Public Relations of the American Medical Association, looking for advice and coöperation from the A.M.A. A committee consisting of Dr. Thomas A. McGoldrick and Dr. Louis H. Bauer, of New York, has been appointed to represent the A.M.A. in conferences with the American Cancer Society in this matter.

There is an additional factor in California that complicates the situation. The Donner Foundation of New York is intensively interested in "prevention clinics" and its representative has been in California encouraging the formation of such clinics and advising methods of procedure. This work of the Donner Foundation is independent of the American Cancer Society.

The Cancer Commission, at your direction, has surveyed the two clinics in California. The Commission, however, should not be expected to render a formal report until the American Cancer Society has developed its policy and until this policy has been approved by the A.M.A.

Respectfully submitted,

(Signed) *LYELL C. KINNEY,*  
*Lyell C. Kinney, M.D., Chairman,*  
*Cancer Commission.*

• • •

The President and the Council,  
California Medical Association.

Gentlemen:

The Cancer Commission looks forward to laying the groundwork of a cancer control program which can be further developed as soon as our members are released from military service. The proposed program is as follows:

1. A survey of the State to see what facilities are available for the diagnosis and treatment of cancer and what facilities are needed to cover the State.

2. To encourage county societies or groups of societies to sponsor and develop the necessary cancer clinics, preferably in approved general hospitals.

3. To encourage each clinic to make a consultative service available to all physicians in the county for their cancer patients irrespective of their financial status.

4. To promulgate standards for clinics in smaller communities not in a position for full approval by the American College of Surgeons.

5. To provide periodic consultation clinics in smaller communities by a visiting team when requested by the county medical society.

6. To organize a cancer committee in every county medical society to coöperate with the Field Army of the American Cancer Society and to supervise their activities.

7. To develop an educational program for physicians. This would include distribution of a cancer manual for office reference after the material and the method of distribution have been approved by the Council. Also, to arrange for postgraduate articles in the Cancer Commission column of CALIFORNIA AND WESTERN MEDICINE. Also, to coöperate with the committee on postgraduate activities of the C.M.A. to provide programs for county medical societies.

8. To develop a tumor registry, preferably under the control of the Cancer Commission or the State Department of Health.

9. If the Council will approve and direct the Cancer Commission to do so, the members of the Commission will form a majority of the Executive Committee of the California branch of the Field Army of the American Cancer Society.

If the members of the Cancer Commission are directed by the Council to function also on the Executive Committee of the Field Army, they will attempt to carry out

the "C.M.A. Formula for Organization of the Field Army in California." The following objectives of the Executive Committee are proposed:

1. That the entire cancer program in California shall be developed in coöperation with and under the supervision of the C.M.A. and the county societies.
2. To employ an executive secretary similar to that of the California Tuberculosis Association to assist the Commander of the Field Army in personal contacts with all county units.
3. To obtain proper publicity for and public support of approved cancer clinics.
4. To assist and direct the educational program of the Field Army and encourage county medical societies to do likewise.
5. To direct the expenditure of money raised in the annual campaign into the most effective channels for cancer control.

Suitable projects have been proposed for the expenditure of campaign money:

1. Distribution of educational literature.
2. Three or more local offices with clerical help and cancer information centers throughout the State.
3. An executive secretary.
4. Assist approved cancer clinics in financing clerical help, nursing or social service personnel as may be needed by these clinics.
5. Plan the transportation of patients to clinics or physicians.
6. Provide for the care of terminal cancer cases.

This is an extensive program which cannot be carried out without the support of the profession throughout the State. If the program is approved by the Council it is the intention of the Commission, in its dual capacity, to keep the State office of the C.M.A. constantly and fully informed of all developments. It is also the intention of the Commission to refer to the Council immediately any changes in policy or any project not fully covered by the above program. The Council is requested to criticize, revise, approve or disapprove the above program as they see fit. In addition, the Council is requested to authorize President Gilman, acting for the C.M.A., to nominate members for the Executive Committee of the California Field Army of the American Cancer Society.

Respectfully submitted,

(Signed) LVELL C. KINNEY,  
*Lyell C. Kinney, M.D., Chairman,  
Cancer Commission.*

#### 10. C.M.A. Advisory Planning Committee:

The C.M.A. Advisory Planning Committee, authorized by House of Delegates Resolution V at this year's Annual Session (June C. & W. M., pages 328 and 340), and consisting of Messrs. John Hunton, Executive Secretary of the California Medical Association; Howard Hassard, Associate Legal Counsel; Stanley K. Cochems, Executive Secretary, Los Angeles County Medical Association; Rollen Waterson, Executive Secretary, Alameda County Medical Association; Ben H. Read, Secretary, Public Health League of California; and W. Glenn Ebersole, Special Representative of the C.M.A. Council, submitted a report prepared at a meeting held on Saturday, August 11. Chairman John Hunton made oral comment on the recommendations submitted with Council action as follows:

(a) The Committee recommended to the Council that the plan of campaign outlined by Mr. Whitaker at the 1945 Annual Session be instituted immediately and that Mr. Whitaker be employed to manage the campaign. Approved by the Council.

(b) The Committee recommended that a series of public health meetings on medical topics of public interest

which the Los Angeles County Medical Association has planned be made available to all other county societies and that all county societies plan to hold simultaneous meetings on the same subjects. The Los Angeles County Medical Association will be glad to furnish release copies to other county society units. Approved.

(c) The Committee recommended that several agreements reached by Doctors Gilman and Murray with officers of the Woman's Auxiliary be approved by the Council. These agreements referred to the monthly publication of "The Courier," a closer working arrangement between the Auxiliary and the C.M.A., the wider use of the Auxiliary in legislative activities and greater encouragement for the Auxiliary by the C.M.A. Approved.

(d) The Committee recommended that the Council request all medical schools in California to institute a one-year required course in medical economics, instructors for which would be selected by the C.M.A. The Council voted to inquire of the medical schools on the feasibility of such courses.

(e) The Committee recommended that each county medical society institute a course of indoctrination for membership applicants, to consist of at least six meetings and to cover the relationship of the individual physician with his fellows and his community. Approved.

(f) The Committee submitted to the Council a suggested statement of "Principles of the C.M.A. on Health Insurance." After discussion and addition of one section covering medical education, this statement was approved as follows (these principles appeared in C. & W. M., for August, 1945, on page 60, in conjunction with the Principles adopted by the American Medical Association on June 22, 1945):

#### PRINCIPLES OF THE CALIFORNIA MEDICAL ASSOCIATION ON HEALTH INSURANCE\*

It is in the public interest that the California Medical Association, representing the doctors of medicine practicing their profession in the State of California, publicly make known the principles which should form the basis of any health insurance program, and from which there should be no material deviation if the public welfare is to be properly and adequately protected. The public health and good medical practice are inextricably interwoven and interdependent.

This statement is made with the understanding that the public is entitled to the best possible quality of medical service and access thereto. The medical profession must be in a position to render such service if the best interests of the public are to be served.

The manifold and constant advances in the science and practice of medicine are put to public benefit only when they can be utilized by an alert and progressive medical profession. The public is entitled to profit by all scientific advances and the public welfare demands that the medical profession have complete scientific freedom in their application.

Any sound health insurance program should fulfill each of the following basic points:

1. It is of primary importance that the people should be enabled to provide for the costs of illness on a regular budget basis during periods of good health and stable earning power, so that they may have medical-economic security. It is vital, however, that the distribution of costs should be undertaken in a manner which will still guarantee the finest possible medical care and which will prevent any deterioration in the quality of medical service.

2. To serve the ultimate public interest any health insurance plan must,

- a. Be voluntary and not compulsory in nature,
- b. Retain individual initiative in medical practice, so that the incentive for further advance in scientific medicine may continue,
- c. Fully protect the freedom of choice, both of the patient in choosing a physician and of the physician in choosing his community, type of practice and professional procedures,
- d. Offer medical care in coöperation with allied services against serious illness or injury,

\* For full page display of these principles, see CALIFORNIA AND WESTERN MEDICINE, for August, 1945, on p. 61.



e. Offer participation at a cost within the means of all employed persons and income-receiving families, and

f. Provide a fair reward to those rendering the service which will give continued stimulus to scientific medical development and sound medical practice.

3. The function of state governments should be to encourage voluntary health insurance programs but not regiment the patient and the medical profession or operate compulsory health insurance plans established by political means; to further this function, the state should cooperate with medical and allied professional groups to provide the availability of medical and associated care through acceptable prepayment plans in areas where a shortage of medical and hospital facilities exists.

4. It is in the public interest that the human factor in medical care be thoroughly recognized; the sanctity of the patient-physician relationship must be maintained and the method of providing medical care must not become enmeshed in bureaucratic red tape and a system of tickets, coupons, questionnaires and other political controls and delays.

5. It is essential for the public welfare that there exist in each state a complete inventory of all medical resources and existing facilities. It is in the public interest that a coherent and comprehensive educational program be undertaken, preferably by responsible authorities and the medical profession in a coordinated effort, to advise all the people of the state on the facilities and services available to them in the event of need and to encourage sound public health measures for the prevention of both accidental and non-accidental illnesses and injuries.

6. There should be a coordinated program on the part of all groups concerned with this problem, directed to the extension of voluntary health insurance plans, so that our people may systematically provide for their health care on a budget basis.

7. Any plan of health insurance must make provision for the maintenance of a high standard of medical education.

#### 11. Special Committee on Prepayment Plans and C.P.S.:

The Special Committee on Prepayment Plans and C.P.S., through its chairman, Loren R. Chandler, reported that this committee had had only one organization meeting but had in contemplation two meetings in the near future, after which a report would be submitted in due course to the C.M.A. Council. (Reference to this committee was made in CALIFORNIA AND WESTERN MEDICINE, for June, 1945, on page 347, under Item 5.)

#### 12. Committee on Public Policy and Legislation:

(a) For the C.M.A. Committee on Public Policy and Legislation, and the work carried on at this year's biennial session of the California Legislature, report was made by the committee chairman, Dwight H. Murray, who, on behalf of his committee, desired to express appreciation for the services rendered by physicians throughout the State, with special thanks to the members of the profession resident in Sacramento and to State Association officers and others who made repeated trips to the Capitol.

Doctor Murray also spoke of the recent meeting in Denver called at the instance of the Michigan State Medical Society on June 28-29, 1945, at which some seventeen states were represented. The problems in Michigan are similar in some respects to those in California. It was there agreed voluntary plans of medical and hospital care should be promoted. It was also agreed that the better organized state medical associations have an obligation to cooperate and give aid in these matters to smaller constituent state medical units needing such help.

(b) Informal discussion was had concerning prospective legislation which might be submitted to Congress through certain Senators.

(c) The extent to which the California Medical Association should give financial cooperation to the United Public Health League was also discussed. The initial appropriation was authorized on January 23, 1944, by the Council for approximately \$18,000, the same being on the basis of \$3.00 for every C.M.A. member paying dues.

After discussion, it was agreed that the \$3.00 allocation

for each member who is paying dues should be again authorized.

In connection with the work of the United Public Health League, Mr. James J. Boyle, Washington representative of the United Public Health League, was called on to make report.

(d) Mr. Fred Kraft, Assemblyman from San Diego, had been invited to be present, and made a short address concerning the problems that had come up during this year's legislative session in connection with proposed statutes having relation to medical care. Mr. Kraft stressed the importance of a campaign of education through which citizens everywhere would be able to obtain the proper orientation of the extent and significance of medical care and other issues involved.

(e) Mr. Clem Whitaker, who has been carrying on public relations work for the California Medical Association during the last year, was also called upon for comment. He outlined his observations of what had taken place and indicated what he thought was ahead.

(f) Mr. Ben Read, Secretary of the Public Health League of California, also made comment concerning this year's legislative battles.

#### 13. Legal Department:

(a) Mr. Peart called attention to the fact that the *Surcharge Order* granting a 15 per cent increase in fees over the present Industrial Accident Commission fee schedule would terminate by its terms at the expiration of six months after the duration, and suggested that a new application be filed during this six-month period. The attorney pointed out that under the act passed at the last Legislature, the Industrial Accident Commission had been reorganized and the Commission would now consist of five members; that the terms of two of the present Board of three had already expired. Furthermore, that the Assembly had appointed an interim committee on the subject of insurance with express provision made for an examination and report in the matter of medical fees in compensation cases.

The attorney further reported that Pacific Employers Insurance Company had refused to add the amount of the surcharge to a bill rendered by Dr. Allan L. Bramkamp of Banning, which surcharge amounted to the sum \$1.14. Dr. Bramkamp referred the matter to the legal department; that he had promptly prepared a petition for the allowance of the surcharge and had returned its check to the insurance company advising it of the doctor's intention to petition for the correct amount of his bill, and that the insurance company had thereupon paid the bill in full.

After discussion, on motion duly seconded and unanimously adopted, the present committee was instructed to proceed with a new application, at such time as it seemed advisable, said committee consisting of Dr. Gilman, Mr. Hunton, and Mr. Peart.

Mr. Peart further suggested that the proposed fee schedule should be again submitted to the fee schedule committee for final check and approval.

(b) Concerning *Sales Tax on Roentgenograms*, the General Counsel reported that the State Board of Equalization had interpreted Rule 23 of the Board to include a sales tax on the furnishing of Roentgenograms, termed in the rule "x-ray pictures." The position of the Board appeared to be that as lay laboratories had been held to be retailers and subject to the tax, in order to avoid discrimination it was deemed necessary to classify professional laboratories likewise as retailers.

Acting under the direction of the Executive Committee, the Legal Department submitted briefs and authorities to the counsel for the State Board of Equalization and obtained a ruling that the tax would apply to the fair retail

value of x-ray pictures or negatives only where there is an actual sale, that is transfer of title by the producers thereof, and that if the producer retains ownership of the pictures or negatives he is the consumer of the film and other materials used in their production, and the tax is therefore applicable to the sale of such materials to him.

Mr. Peart stated that an opinion based upon this ruling had been disseminated among the members specializing in Roentgenology, but that in view of an erroneous article appearing in the *Journal of the American Medical Association*, Mr. Hunton had prepared an additional article for publication in *CALIFORNIA AND WESTERN MEDICINE*, so that all members of the Association would be fully advised of the State Board's interpretation of the rule and of the governing facts.

#### 14. House of Delegates Resolution No. 6:

House of Delegates Resolution No. 6, presented at this year's Annual Session, and appearing in the June, 1945, C. & W. M., on pages 329 and 342, was referred to in a letter received from Mr. James A. Vincent of the Christian Science Committee on Publications for Northern California.

It was voted that the communication be placed in the files.

#### 15. C.M.A. Physicians' Benevolence Committee:

(a) *C.M.A. Benevolence Fund*.—Councilor Axel E. Anderson, Chairman of the C.M.A. Physicians' Benevolence Committee, made report concerning the work of the committee, with special reference to the conditions in Los Angeles County, where some 93 individuals receive aid, more than one-half being widows of physicians. In Los Angeles, with the aid of the Los Angeles County Medical Association, the monthly outlay is something like \$800. After discussion, the Council voted to approve the committee's recommendation that the allocation to Los Angeles County from the C.M.A. Benevolence Fund be increased from \$300 to \$500 per month.

(b) *Physicians' Aid Association of Los Angeles County Medical Association*.—Chairman Anderson also called attention to the campaign which had been inaugurated by the Los Angeles County Medical Association to build up an independent Benevolence Fund, stating that to date in that county the sum of \$150,000.00 had been secured for such objective, the campaign to raise a fund of \$500,000.00 for that county still going on.

#### 16. Proposal for a Special Committee on Nutrition:

Concerning letters and proposals submitted by Francis M. Pottenger, Jr., of Los Angeles County, in re: a special committee on Nutrition, Council Chairman Gilman stated that he had taken up the matter with Vice-Speaker Alesen and that the subject would be referred to Mr. Clem Whitaker for consideration. The Council Chairman's action was approved.

#### 17. Sickness Insurance Legislation and Principles:

Reference was made to the platform adopted by the A.M.A. Council on Medical Service and Public Relations and adopted by the Board of Trustees of the American Medical Association on June 22, 1945.

The Editor stated that this platform would appear in the August, 1945, issue of C. & W. M., on page 61, and that the C.M.A. Principles on Health Insurance, as adopted by the Council at this present meeting, would also be printed in conjunction therewith.

#### 18. Communication from Foote, Cone and Belding:

A communication from Foote, Cone and Belding concerning a public educational program was referred by the Council to Mr. Clem Whitaker for consideration and report to the Council Chairman.

#### 19. Time and Place of Next Meeting:

In accordance with past custom, the next meeting of

the Council will be held in Los Angeles some time during the fall, the time and place to be decided by the Council Chairman.

#### 20. Executive Session:

The Council went into Executive Session.

(a) *Employment of Public Relations Representative*.—Discussion was had concerning the importance of an active educational campaign with special reference to proposed legislation dealing with compulsory and voluntary medical care plans. After discussion, it was voted that Mr. Clem Whitaker of San Francisco be employed and that the C.M.A. Executive Committee be authorized to make the necessary arrangements in regard to term of employment and financial remuneration.

(b) *Employment of Special Council Representative*.—Council Chairman Gilman stated that Mr. Glenn Ebersole had been making a first-hand investigation of medical care and hospitalization plans in different States in the Union in order that proper report could be made thereon.

Concerning terms of employment of Mr. Ebersole, it was agreed that this should be at the discretion of the Chairman of the Council.

(c) *Clearing Officer*.—It was agreed that the plan in use during the last session of the Legislature whereby the Executive Secretary, John Hunton, would be the clearing officer for legislative publicity, etc., should be continued.

(d) *Educational Campaign Under Auspices of C.M.A. Committee on Public Policy and Legislation*.—Full discussion took place concerning the work of the C.M.A. Committee on Public Policy and Legislation, its responsibilities and future activities.

It was voted that the sum of \$10,000 be allocated for use by the Committee on Public Policy and Legislation as conditions would warrant drafts thereon.

(e) *Honorable Retirement of the Secretary-Editor*.—The many years of service given by Dr. George H. Kress, Secretary-Editor of the California Medical Association, was called to the attention of the Council by Chairman Gilman.

After discussion it was unanimously voted that the Secretary-Editor would be granted honorable retirement immediately following the 1946 Annual Session, such retirement to be accompanied by the payment of a suitable life pension in an amount to be determined by the Executive Committee and in keeping with the value of the services rendered by the Secretary-Editor over a long period of years.

Mention was made that a history of the California Medical Association, now in its seventy-fifth year, had never been written. Also, that the retiring Secretary-Editor had had in mind the collection of historical data that would make possible the production of a history of the California Medical Association. Councilors expressed themselves as believing such a plan should be developed.

(Note. The above minute concerning the Secretary-Editor submitted by Dr. Philip K. Gilman.)

#### 21. Adjournment:

There being no further business, on motion made and seconded, it was voted to adjourn.

PHILIP K. GILMAN, M.D., *Chairman*,  
GEORGE H. KRESS, M.D., *Secretary*.

Amidst the calamities which war has brought on our country this one benefit has accrued—that our eyes are withdrawn from England, withdrawn from France, and look homeward. We have come to feel that "by ourselves our safety may be bought."

—Emerson, *Letters and Social Aims: Social Aims*.



# EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

## *Minutes of the One Hundred Ninety-fifth (195th) Meeting of the Executive Committee of the California Medical Association*

The 195th meeting of the C.M.A. Executive Committee was held in San Francisco on September 26, 1945, at 6:30 P.M.

### 1. Roll Call:

Members Present: John W. Cline, Executive Committee Chairman; Philip K. Gilman, Council Chairman; Sam J. McClendon, President-Elect; E. Vincent Askey, House of Delegates Speaker; and George H. Kress, Secretary.

Present by Invitation: John Hunton, Executive Secretary; and Howard Hassard, Associate Legal Council.

### 2. Communication from the Blue Cross Committee of the Association of California Hospitals:

The special subject for discussion was a communication received from George U. Wood, Chairman of the Blue Cross Committee of the Association of California Hospitals, the same referring to plans related to voluntary prepayment medical and hospital activities, with suggestions concerning certain features thereof.

The objectives proposed and the individual items were given extensive discussion and careful consideration.

The conclusion finally reached was that a reply should be sent to the Blue Cross Committee of the Association of California Hospitals, informing the Association of California Hospitals that the Executive Committee of the California Medical Association was in favor of the proposal to mutually develop a uniform plan for the State of California concerning voluntary prepayment medical and hospital service plans and that if the Association of California Hospitals will carry through their proposal concerning hospitalization procedures in relation thereto, it was felt the California Medical Association would be happy to confer further concerning details. Also, that thanks be expressed to the Association of California Hospitals and its Blue Cross Committee for this follow-up expression of earlier joint conferences with the C.M.A. in relation to the problems at issue.

Upon motion made and seconded, it was so voted, and it was agreed that a communication in line with the above should be formulated and sent to the Association of California Hospitals and its Blue Cross Committee, of which George U. Wood is chairman. (See also p. 156.)

### 3. Dues of Military Members:

Informal comment was made concerning state association dues of military members and it was agreed that this item should be placed in the agenda of the Council meeting to be held on October 21, 1945, in Los Angeles.

### 4. Adjournment:

There being no further business, it was voted to adjourn.

JOHN W. CLINE, M.D., *Chairman*  
GEORGE H. KRESS, M.D., *Secretary*

### A.M.A. House of Delegates to Convene in Chicago on December 3, 1945

The annual meeting of the House of Delegates, the policy-making body of the American Medical Association, will be held in Chicago for four days, beginning December 3, 1945.

The annual session, usually held in June, but delayed this year because of wartime travel restrictions, was called by Herman L. Kretschmer, M.D., Chicago, President of the A.M.A., and H. H. Shoulders, M.D., Nashville, Tenn., Speaker of the House of Delegates. The meeting, which will be held in the Palmer House, is ex-

pected to bring together approximately 200 delegates and officials of the Association, coming from all parts of the country.

During the session, Dr. Kretschmer will relinquish the presidency of the Association and will be succeeded by Roger Irving Lee, M.D., of Boston, who was chosen president-elect at the wartime session of the A.M.A., which was held in Chicago in June, 1944.

The December session of the House of Delegates will be devoted to consideration of many problems of great significance for the future of medical practice. Many questions related to medical services and policies for the medical profession will be presented. Maintenance of a high quality of medical service, a high standard of medical education, and a wider distribution of good medical care to all the people are among the topics to be considered.

Because of the war, the annual A.M.A. convention could not be held in New York this year. A wartime session, attended by more than 7,000, was held in Chicago last year. San Francisco was selected some years ago to play host to the 1946 convention.

At a meeting of the A.M.A. Board of Trustees held in September, 1945, it was deemed advisable to recommend that the 1946 A.M.A. be held during July or August, on dates to be selected later.

### C.M.A. Council Meeting in Los Angeles

A meeting of the Council of the California Medical Association will be held in Los Angeles on Sunday, October 21 (in Conference Room, Hotel Biltmore, at 10:00 A.M.).

### C.M.A. Committee on Prepaid Medical and Hospital Care

At the House of Delegates meeting of the California Medical Association held in Los Angeles on May 7, 1945, the chairman of the Council was instructed to appoint a State-wide representative committee to study the work of prepaid medical and hospital plans and procedures in California including California Physicians' Service, the committee so appointed to report at meetings of the Council and submit recommendations to the next House of Delegates meeting.

The Chairman of the Council has appointed the following committee: Doctors L. R. Chandler, chairman, H. E. Henderson, Sidney J. Shipman, Jay J. Crane, Samuel Ayres, Jr., Peter Blong, J. E. Young, M. A. Hopkins, A. E. Moore, William Donald and A. M. Meads.

This committee held its organization meeting on Sunday, July 15, 1945, and the following purposes and duties of the committee were defined: (1) To study California Physicians' Service and other prepaid medical and hospital care plans, both voluntary and compulsory, (2) To make periodic reports to the Council of the California Medical Association, (3) To make such recommendations concerning the subject of study as the committee may consider advisable to the House of Delegates of the C.M.A. at its next regular meeting. It was agreed and understood that committee reports or parts thereof submitted to the Council may be published for the interest of the medical profession in CALIFORNIA AND WESTERN MEDICINE when so requested by this committee.

The committee will welcome constructive suggestions in connection with its study as outlined above. The committee will also welcome a report of any experiences physicians may have had with prepaid medical care in order to aid it in reaching conclusions and making recommendations, both to the Council during the year, and the House of Delegates at its next meeting.

## COUNTY SOCIETIES†

### CHANGES IN MEMBERSHIP

#### New Members (14)

##### *Alameda County (1)*

Buckingham, Dewitt A., *Oakland*

##### *Fresno County (2)*

Buel, Walter H., *Arwahnee*

Montgomery, John R., *Fresno*

##### *Los Angeles County (1)*

Sekiyama, Isami, *Los Angeles*

##### *Orange County (1)*

Wehrly, Mildred, *Santa Ana*

##### *San Diego County (2)*

McSparran, Joseph L., *San Diego*

Murrill, William A., *San Diego*

##### *San Francisco County (6)*

Armanino, Louis Peter, Jr., *Stockton*

Baum, Max, *San Francisco*

Feher, George Schubert, *San Francisco*

Petit, Donald William, *Randolph Field, Texas*

Schwalb, Otto B., *San Francisco*

Schring, Maxine Moore *San Francisco*

##### *San Mateo County (1)*

Gaard, Genevieve, *San Carlos*

#### Transfers (1)

Gray, Claude C., from *San Francisco County* to *Sacramento County*

## In Memoriam

**Aland, Albert Harold.** Died at West Los Angeles, July 24, 1945, age 57. Graduate of Western Reserve University School of Medicine, Cleveland, Ohio, 1916. Licensed in California in 1944. Doctor Aland was a member of Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Allan, James T. M.** Died at Los Angeles, August 26, 1945, age 75. Graduate of the University of Southern California School of Medicine, Los Angeles, 1903. Licensed in California in 1903. Doctor Allan was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Axline, Joseph T.** Died at North Hollywood, August 14, 1945, age 63. Graduate of St. Louis University School of Medicine, Missouri, 1906. Licensed in California in 1922. Doctor Axline was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Babcock, Edward Saunders, Jr.** Died at Sacramento, September 3, 1945, age 47. Graduate of the University of California Medical School, Berkeley-San Francisco, 1923. Licensed in California in 1923. Doctor Babcock was a member of the Sacramento Society for Medi-

cal Improvement, the California Medical Association, and a Fellow of the American Medical Association.

**Davis, William Dewey.** (Captain, United States Army.) Killed on the USS Comfort, April 28, 1945, age 32. Graduate of the University of Chicago, the School of Medicine, Illinois, 1939. Licensed in California in 1940. Doctor Davis was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Fairchild, Chester Hyman.** Died at Woodland, September 6, 1945, age 75. Graduate of Cooper Medical College, San Francisco, 1906. Licensed in California in 1906. Doctor Fairchild was a Retired Member of the Yolo County Medical Association, and the California Medical Association.

**Holzman Albert Joseph.** Died at Santa Barbara, August 21, 1945, age 51. Graduate of Rush Medical College, Illinois, 1929. Licensed in California in 1929. Doctor Holzman was a member of the Santa Barbara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

**Keltz, Charles.** (Captain, United States Army.) Killed in action, October 24, 1944, place of death unknown, age 37. Graduate of the University of Southern California School of Medicine, Los Angeles, 1929. Licensed in California in 1933. Doctor Keltz was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**McKee, Albert Brown.** Died at San Francisco, August 19, 1945, age 83. Graduate of the Cooper Medical College, San Francisco, 1886. Licensed in California in 1886. Doctor McKee was a Retired Member of the San Francisco County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

**Neumann, Ernst Valentine.** Died at Hollywood, August 14, 1945, age 65. Graduate of Creighton University School of Medicine, Omaha, Nebraska, 1913. Licensed in California in 1926. Doctor Neumann was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Rogers, Henry Stanley.** Died at Finley (Lake County), September 14, 1945, age 61. Graduate of Creighton University School of Medicine, Omaha, Nebraska, 1915. Licensed in California in 1917. Doctor Rogers was a member of the Sonoma County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**Van Meter, Fletcher Jackson.** Died at Yucaipa, August 4, 1945, age 62. Graduate of Drake University College of Medicine, Des Moines, Iowa, 1906. Licensed in California in 1926. Doctor Van Meter was a member of the Mendocino-Lake County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

†For roster of officers of component county medical societies, see page 4 in front advertising section.



**Young, Dwight Dunham.** (Commander, United States Navy). Died May, 1945, place of death unknown, age 43. Graduate of Columbia University College of Physicians and Surgeons, New York, 1928. Licensed in California in 1929. Doctor Young was a member of the Orange County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

## COMMITTEE ON ORGANIZATION AND MEMBERSHIP

### San Francisco County Medical Society Plans New Home

*Following item appeared in October Bulletin of the  
San Francisco County Medical Society*

In the near future the County Society will vote upon certain plans regarding its Washington Street headquarters of the San Francisco County Medical Society. In this connection the following facts are submitted to the membership in an open letter by the president:

Dear Doctor:

The present period of postwar reconversion presents an excellent opportunity to take stock of the physical equipment and properties of the San Francisco County Medical Society.

At the present time we have on our rolls a paying membership of 823 and an additional 406 members serving in the armed forces. An increasing number of these men and women are now returning to private practice.

We also own clear the property at 2180 Washington Street. We possess a library in this building and have a vested interest in the Irwin Memorial Blood Bank. We have in addition a moderate sum of money in the bank and have built up a considerable fund for the use of returning war veterans to help them become reestablished in private practice.

We recently have acquired the services of a full-time executive secretary, Mr. Frank J. Kihm, whose duties will be to extend many of the present activities of the County Society of a business and organizational nature.

*The Building at 2180 Washington Street.* This building, as you know, was originally erected as a private mansion by one of the early California millionaires and is an exceedingly ornate building beautifully finished within and without. It is now close to 50 years of age. Its exterior is deteriorating rapidly and the interior is in constant need of repairs, particularly in regard to plumbing.

Taxes to the City and County of San Francisco amount to \$5,300 annually.

The building was acquired by the San Francisco County Medical Society late in the year 1926. It may be concluded that the building as it now stands will never again be utilized as a private residence. On the other hand, it is ill-adapted to the particular needs of a scientific society such as the San Francisco County Medical Society. The Society needs for its purposes a properly ventilated lecture hall with suitable acoustics and relatively small space for the maintenance of its records, files, and a meeting place for smaller groups such as the directors, and little beyond that.

The question now arises, since the building is paid for and the County dues will be quite high—what would be the best disposition to make of the present property? Should it continue to be used in its present form with the limitations that it obviously presents; should it be remodeled to fit the requirements of the Society; or should it be disposed of? Another alternative would be

to dispose of the building and upper half of the lot and construct more suitable quarters on the lower section fronting Jackson Street.

The building as it stands, while a Class A building, is not desired by any real estate brokers and would undoubtedly be torn down, and at considerable expense. The lot on which the building stands in its present zoning is worth about \$75,000. If we were able to have the district rezoned to permit an apartment house building, we could probably expect \$150,000 for the lot and nothing for the building.

*The Library.* While the library of the Society contains approximately 15,000 volumes, many of these are in the form of obsolete textbooks. These books are of little value. We do possess a number of important files of periodicals which are in good condition. The library as such is rarely used by the members and should members require a library study of any particular subject, undoubtedly the facilities of the two university libraries containing many more complete periodical files are much more desirable. The Board of Directors has considered and in fact authorized the disposal of the present County Society library and a committee composed of Drs. F. L. Reichert, L. R. Chandler, M. W. Debenham, M. L. Montgomery and C. D. Horner is to study the matter. As yet no report has been received. It would seem that there is little need for the County Society's attempting to maintain a medical library in a city in which the two best libraries on the Coast are already situated.

*Meeting Hall.* The matter under consideration by the Board of Directors is whether one of the two following plans would or would not be desirable: (1) After the disposal of the present property, should this be possible, to sign a long-term lease in some building, the construction of which is now contemplated by others, for quarters which would be specifically constructed in accordance with the requirements of the County Society including suitable auditorium, suitable small meeting places and suitable quarters for our office staff, or (2) whether property should be acquired in some reasonably centralized area, although not downtown, where the ground space would not be excessively expensive and where parking facilities would be available, and there construct a one-story building for the special purposes of the Society.

It should be emphasized in connection with the first option (leasing space in a new downtown office building) that rentals for adequate space would be extremely high and out of line with the Society's revenues. For this reason the Board of Directors seriously questions its feasibility.

The future disposition of the Irwin Memorial Blood Bank does not conflict with the above plans since suitable arrangements can be worked out for this department without a great deal of difficulty.

The attention of the membership is earnestly requested on the above subject, and it is hoped that as many as possible will express their views on ballot-forms to be sent out shortly so that the Board of Directors may be guided in its future deliberations.

Yours very truly,

G. DAN DELPRAT, M.D., *President.*

When honored and decrepit age shall lean against the base of this monument, and troops of ingenuous youth shall be gathered round it, and when the one shall speak to the other of its objects, the purposes of its construction, and the great and glorious events with which it is connected, there shall rise from every youthful breast the ejaculation, "Thank God, I—I also—am an American!"

—Daniel Webster, *Address*, Charlestown, Mass., 17 June, 1843, at completion of the Bunker Hill Monument.

### Alameda County Medical Association

#### *President's Message—The Problem of C.P.S. and Unity in California Medicine*

For several years the Alameda County Medical Association has been officially critical of several features of California Physicians' Service. In the first place, we have felt that its "service" plan, under which physicians are paid by "units," was actuarially and economically unsound and that it constituted a form of agency control, even though set up by our own fellow physicians.

That our repeated criticisms have been constructive and worthwhile is evidenced by several improvements which have been made in the management and business procedures of the organization. Full coverage policies have been eliminated, and experienced business men have been hired to manage the business. It is admitted that these changes have been at least partly brought about as a result of the efforts of the Alameda County physicians.

So far, so good.

However, our constructive criticism of C.P.S. and our attempts to change it to the indemnification plan of insurance have not been productive of good feeling between our county and our state organizations. A lack of unity has resulted, the blame for which cannot be said to rest entirely on the shoulders of either organization.

No thinking man could possibly have observed the happenings throughout the world within the last decade without realizing that a great force of leftism is threatening society in general, and medicine in particular. We do not need to rely upon the statement of the officers of C.M.A. that we and the public are imminently facing the dangers and evils of compulsory health insurance. We have recently seen such measures defeated by a narrow margin in our Legislature, and we have, at the moment, information that the proponents of these schemes, formerly divided in their attacks, are now teaming up to put over their ideas. In order to defeat them, we must have coöperation between the liberal and sound citizens of the State, business organizations, insurance companies and the medical profession. To coöperate effectively with allies, who have come to our assistance in our own battle for professional freedom, we must have unity within our own ranks.

The Alameda County Medical Association sincerely believes that the best way to obtain such unity would be to convert C.P.S. to indemnity, a form of voluntary health insurance which every doctor of California could honestly and enthusiastically sell to his patients. At the last meeting of the House of Delegates, we secured the appointment of an impartial committee, headed by Dr. L. R. Chandler, to study this problem. This committee must report its findings and recommendations to the next meeting of the House of Delegates.

Inasmuch as a compulsory health insurance bill probably will be introduced at an early session of the Legislature, it is important that Dr. Chandler's committee and the House of Delegates act as soon as possible. Following the presentation to the physicians of California of the information gathered by this committee, for their study and evaluation, it would be a simple matter to conduct a plebiscite by mail of all members of the California Medical Association, asking them to state their preference for either an indemnity plan or a service plan in C.P.S. as a guide to the action of the House of Delegates. I have personally suggested this to the officers of the C.M.A.

My suggestion of a plebiscite is made with a full understanding of both my privileges and responsibilities as a member of a democratic organization. My democratic *privilege* is to express myself upon any question, to attempt to induce others to accept my viewpoint, to be

heard either directly or by representation, and then to have a vote. My *responsibility* is to bow to and support the will of the majority if the vote does not favor my opinion. But it is also my privilege to again present my views at the next opportunity and, if I am then successful in influencing a majority, it will be the responsibility of those who once disagreed with me to support my opinion or my plan.

Therefore, after we of Alameda County have done our best to convince the doctors of California of the value of the indemnity plan, after Dr. Chandler's committee has studied its merits, after a plebiscite has been held and after the House of Delegates has given it a fair hearing, I feel that the Alameda County Medical Association, as members of a democratic organization, should support the action of the majority of the House of Delegates.

In the meanwhile, until we are satisfied regarding what the majority of the physicians of California want done with C.P.S., the big issue is voluntary as against compulsory health insurance. And we of Alameda County should be selling the fundamental American concepts and the advantages of voluntary insurance to our patients. As individuals, we may sell the *type* of voluntary plan in which we believe—Blue Cross, commercial plans, or C.P.S.—but we must sell *voluntary* insurance.

In brief, I feel that the greatest danger that threatens the health of the public and the practice of medicine is compulsory health insurance, and that it is wise for us to make every effort to gain unity in our own ranks in order to bring our full potential strength into the coming struggle with the now unified and united proponents of this greater evil.—Dr. Harry J. Templeton's message in October "*Bulletin*" of Alameda County Medical Association.

### Los Angeles County Medical Association

#### *"The State of the Association"*

In *The Bulletin* of the Los Angeles County Medical Association, issue of September 20, appears an editorial by the Association Secretary, Doctor E. T. Remmen, under the caption, "The State of the Association." Secretary Remmen's discussion of the activities of this component county society (with its membership in excess of 3,000, one of the largest in the United States) is of sufficient interest to be called to the attention of other component county units.

Few county organizations are able to present financial and other reports, so satisfactory. Article follows:

It is the traditional duty of the secretary, from time to time, to report to the membership concerning the activities, assets, obligations and problems of their Association. Actually, of course, though *The Bulletin* and the numerous general, section, and branch meetings, all interested members are already well informed, at least as to those matters in which they particularly are interested. Nevertheless, a résumé may be of value.

#### *Problems of Reconversion:*

The return of many of our members who have been in service presents problems which are not yet clearly defined. We do not know how many men will be quickly released, nor how many will remain in the service, either permanently or for a long time. A number may remain with the Veterans' Administration or with other governmental agencies. Those who do return will sometimes find their old offices occupied by other doctors or by persons engaged in other lines of business. As defense plants close and unemployment grows, the demand for medical service diminishes. During the past two weeks it has become difficult to obtain employment on salary for those doctors who desire it.



The story so familiar to those of us who served in the last war is being repeated. When a man enters military service in wartime he is a great hero. As soon as the war ends the glamor evaporates, the canteens close, heroism becomes a bore and the soldier must struggle for his old place against the unequal competition of entrenched civilians. The tendency of human beings to bear resentment against those to whom they are deeply obligated is partly responsible for this attitude, and it is unfortunately aggravated by the very small percentage of veterans, many of whom never saw action or came to any harm, who become pension chiselers, street sellers of worthless "patriotic" trinkets, and whose attitude is that a period of military service, however brief, entitles one to public support and admiration for life.

The Postwar Planning Committee of the Association, in whose capable hands have been placed the problems of the returning veteran members, are themselves almost all veterans of military service. They know the situation from personal experience and will do everything in their power to assist our military colleagues to reestablish themselves in civilian practice. A fund of \$39,257.50, contributed by members, is at their disposal for the purpose. Dr. Donald Charnock is chairman of the Committee. This Committee also has made plans to provide post-graduate training for those who desire it.

One of the first activities of this Committee was to contact medical schools and all hospitals to insure that all teaching and staff positions held by military members would be open upon their return to civil life. Lack of office space constitutes the most serious and difficult problem today. Information relative to this is up to date and available at the office of the Association, together with other information that might be helpful. Salaried positions once plentiful and other openings have largely disappeared with the end of the war.

#### *The Bulletin:*

*The Bulletin* has grown in thirty-five years from a single small sheet bearing a program announcement, to a semi-monthly magazine averaging forty-eight pages. It is the particular problem of your secretary, who is also the editor, and who is most ably assisted by Mr. Cochems as managing editor, Mr. Bert Fitzgerald, who is in charge of advertising, and Miss Katherine Genter, assistant editor.

*The Bulletin* is said to compare favorably with similar publications in other large cities. It is a very necessary medium in a society so large and scattered over so great an area. Paper restrictions during the war have prevented expansion of *The Bulletin*. It should, however, become much more of a vehicle for scientific articles than has been the case. Members are urged to contribute. Papers, for the present at least, should be on topics of general rather than highly specialized interest. The topics need not be medical, but must be of interest to physicians. Brevity is important. Long articles are seldom of interest except to students of a particular topic. Most subjects can be adequately presented in 1,000 to 2,000 words if rehash and unnecessary detail is omitted. Papers presented at meetings, either branch, section or general, should be sent to *The Bulletin* for publication if they are suitable in the opinion of the author and the officers of the group to whom the essay is presented. Much valuable material, now heard by only a small group could be made available in this way to the entire Association. *The Bulletin* pays its own costs of printing and distribution and also a substantial profit to the Association.

#### *Financial:*

The Association is in excellent financial condition. It has no debts, owns valuable real estate, some income producing real estate in addition to that used as headquarters and library. The Medical Milk Commission is

self-supporting. Securities, largely government bonds, are held. Current and past financial statements are on file at the office of the Association and members are invited to inspect them. In recent years dues have been \$37.50 annually. Of this sum \$20.00 has been forwarded to the California Medical Association for its support.

Each branch of the Association is refunded \$5.00 from the dues paid by members of the branch. This is done for the reason that members in outlying cities do not have the same convenient use of the library and headquarters facilities as those who live in Los Angeles. It will thus be seen that the portion of the total dues paid which goes to the local Association is small. Actually, they would have to be much larger if it were not for wise real estate investments in the past and the income provided by *The Bulletin*. Our excellent library and innumerable services to members simply could not be maintained at \$17.50 per year per member.

#### *Association Dues for 1946:*

Although ample publicity has been given to it, some members may not know that the House of Delegates of the California Medical Association voted at its meeting in May to set State dues at \$100.00 for next year. This was done in the belief that in these unsettled times, with problems of reconversion, postgraduate education, rehabilitation of members and legislation pending, the California Medical Association should be in a strong financial position. In all probability, dues will revert to normal for 1947. If our county dues are fixed by the Board of Trustees at the same level as last year, which seems probable, each member will receive a bill for dues next year of \$117.50. It might be well to put \$25.00 a month into the sugar bowl between now and the evil day, which is January 1st, just to soften the blow. The writer has not been greatly impressed with the wisdom of some of the expenditures of our State Association. There may have been a tendency to run after plausible messiahs who promised great accomplishments—for a large consideration. Regardless of past expenditures, the large fund is necessary, and if wisely used and not squandered, it will be well worth while. A heavy responsibility will rest upon the State officers, council and House of Delegates.

#### *The Library:*

Our library has gained international recognition. Its accretions continue and space for books and magazines is again becoming something of a problem. It will be necessary to find additional storage space before many years. Miss Hazel Granger, librarian, has a highly efficient staff, all of whom have been overworked. In addition to the normal demand for research and other service, the military establishments have made heavy demands upon the library staff. Because of wartime restrictions on the employment of labor, it has not been possible to obtain additional librarians.

#### *Medical Milk Commission:*

The supervision of certified dairies and the inspection of milk is one of the oldest activities of the Association. The members of the Milk Commission—Drs. John P. Nuttall, chairman; Oscar Reiss, secretary-treasurer; Philip Stephens, Howard F. West and E. Earl Moody—are to be congratulated on the excellent record they have made.

Certified milk in Los Angeles County today is recognized nationally as the purest and highest quality raw milk ever produced in the history of milk production. The laboratories of the Milk Commission are maintained at 821 West 37th Street, Los Angeles and are the charge of Charles W. Bonyng, M.D., bacteriologist, who has serving with him Dr. J. J. Hird, veterinarian; Gerhard D. Ruth, M.D., medical examiner, and three technicians.

The certified milk production of three dairies, Arden, Adohr, and Jessup Farms, with herds totaling approximately 3,000, comes under the supervision of the Milk Commission. The testing of cattle and milk and also the examination of employees of certified sections of the dairies is a continuous procedure which has been maintained during the war years at a high standard in spite of the difficulty in retaining sufficient personnel.

#### *The Secretary's Office:*

The Association is most fortunate in its employees. In charge is Mr. Stanley Cochems, diplomat *par excellence*, public relations expert, managing editor of *The Bulletin*, and radio commentator. If any other medical organization possesses an executive secretary of equal versatility, soundness of judgment and personal popularity he has not come to your secretary's attention.

Assisting Mr. Cochems are Mr. Bert Fitzgerald, Mabel Robinson, Margaret Eggerts, Mary Thomas, Katherine Genter, Louise Kalinich and Louise Kirnig. The office of the Association is the nerve center of the varied and multitudinous activities of an Association larger and more active than many state medical associations.

Through this office are handled all the financial and routine activities of the various departments of the Association, the library, the Milk Commission, etc. It is the editorial, advertising and circulation headquarters for *The Bulletin*. It is the meeting place for committees charged with protecting and promoting the interests of the profession. From it radiate public relations activities most vital to the maintenance of public respect and understanding. Possibly one of the most important activities of the office and its staff is to keep in constant touch with the status of medicine in this community and the wishes and attitudes of the more than three thousand members of the Association, and to be a source of authentic information for members and the public alike; to be recognized by government agencies, by business organizations and by individuals as the authoritative headquarters for ethical medicine in Los Angeles County. This recognition during the past decade has been achieved.

#### *Medical Malpractice:*

Medical malpractice constitutes one of the most serious problems that the profession has ever been compelled to face. There will be no real solution until every physician becomes cognizant of his responsibility in relation to the problem. That desirable and necessary state has not yet been reached, but great progress has been made.

About one thousand of our members are now participating in the malpractice insurance and claims prevention program of the Association. Among the basic propositions of this program are that premiums will be paid as may be necessary to assure a reasonable profit to the carrier; that a continuous claims prevention campaign be maintained; that claims handling be conducted by specially trained personnel, and that defense of actions be in the hands of the most capable attorneys available.

Much credit must be given to the Committee on Medical Defense—Louis J. Regan, M.D., chairman; J. Severy Hibben, M.D., and Donald Tollefson, M.D. Members of this committee have worked indefatigably and without stint of time to develop a real protection to members of the Association.

#### *Diamond Anniversary:*

On January 31st, next, we will observe the 75th anniversary of the founding of the Los Angeles County Medical Association by a group of seven physicians who met in the offices of Doctors Griffin and Widney in Wohlschlag's drug store near the plaza. Through the years it has grown, slowly and haltingly at times, until it has now become greater than all but a few state medical associa-

tions. A comprehensive history of the Association will be published to mark the occasion. An intensive search for historical material has been in progress for several months and much has been learned.

The real growth of the society began when Doctor George H. Kress assumed the duties of secretary on January 1, 1910. Stagnation had prevailed with no more than four members a year being added in the preceding years. Doctor Kress' enthusiasm and energy was such that fifty-five new members were acquired in his first year, and one hundred-four in the second. When he laid down the reins eight years later, having meanwhile been honored with the presidency of the California Medical Association, the membership totaled 900, an increase of 498. A highly useful telephone exchange, now outgrown, had been put in operation, a library established, and the American Medical Association entertained in annual convention, a building fund of nearly \$10,000 accumulated and interest and fellowship brought to a high level. Organized medicine in California owes much to Dr. Kress. For thirty-five years he has served his profession loyally and unceasingly without thought of reward and at great personal financial sacrifice. No living member of the California Medical Association can even approach his long record of service in planning, organization, editing, historical research and in the fields of medical education, postgraduate training and elevation of standards. It is to be hoped that Dr. Kress, with the youthful vitality and optimistic viewpoint, in which he excels most men twenty-five years younger, may be spared to us for many years and that he may complete the history of medicine in California which he has in preparation.

Succeeding secretaries have also contributed much to the growth and solvency of our county association, and it is planned to pay tribute to them and to other loyal and distinguished officers and members at a banquet for all members, on the evening of Thursday, January 31, 1946.—E.T.R.

## CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

### Release from Army of Doctors Made Easier

An Army announcement on September 14 stated that no officer or enlisted man with 40 or more discharge points will be sent overseas.

The previous overseas point limit for marines was 70.

The Army estimated 13,000 doctors, 25,000 nurses and 3,500 dentists will be civilians again by January 1.

The Army system will be liberalized still further within a few months so that by July 1, 1946, when the Army strength drops to 2,500,000, at least 30,000 doctors, 10,000 dentists and more than 40,000 nurses will be out of uniform.

In addition, large numbers of veterinarians, Sanitary Corps officers, dietitians, physical therapists and medical administrative officers will be released.

### How Release Works

Under the new system, doctors and dentists—with the exception of about 200 specialists—will be released if:

They have 80 discharge points, based on credit for service, combat and parenthood or are 48 years of age or older or entered service prior to December 7, 1941.

The specialists will be released if they have 80 points or are 48 years of age, or if they went on active duty before January 1, 1941.



The discharge score for nurses was lowered from 65 to 35 and the discharge age from 40 to 35. In addition, they also may get out if they are married or have dependents under 14 years of age.

#### **Navy Release Program Told in Senate Quiz**

Vice Admiral Louis E. Denfield, chief of personnel, on September 17, before the Senate Military Committee, testified the Navy plans to release 3,000,000 men by September 1, 1946, bringing the total down to 57,800 officers and 500,000 men.

#### **Surgeon General Kirk Urges Prompt Release of Eligible Personnel**

Major General Norman T. Kirk, in a bulletin dated September 30, 1945, the Surgeon General of the Army, expressed the desire that all commanding officers give the fullest possible coöperation towards effecting the early release of Medical Department personnel who are eligible for separation from the service under the announced policy.

At the same time he urged that all Medical Department personnel occupying key positions and who are eligible for separation under the present criteria volunteer to continue on active duty to assist in maintaining the present high standards of medical care if no replacement is immediately available. It is contemplated that a period of six months' duty will be sufficient time to allow for the arrival of a replacement or for training an officer to take over duties of key positions and thus allow all officers eligible for release to be returned to civilian life.

General Kirk requested that commanding officers make every effort to obtain replacements for Medical Department personnel eligible for release in order that those officers might be returned to civil life at the earliest possible moment.

Under the announced Medical Department demobilization policy, Medical and Dental Corps officers are eligible for release providing they meet any one of the following criteria:

- a. Adjusted service score of 80 or above.
- b. Forty-eight years of age to the nearest birthday or above.
- c. Entry on active duty prior to Pearl Harbor excepting critical specialists qualified in eye, ear, nose and throat, plastic surgery, orthopedic surgery, neuropsychiatry or laboratory clinicians. Officers qualified in these specialties are eligible for release if they entered on active duty prior to 1 January 1941 or if they meet the criteria on points or age.

This revised policy on separation is expected to return 13,000 physicians, 3,500 dentists, 25,000 nurses and a large number of other Medical Department officers to civilian life by the first of the year.

It will be necessary to retain a large number of low score men in the service for replacement for overseas men having high ASR scores. Other low score men must of necessity be retained in the service to carry on the necessary activities of the Medical Department in this country and in theaters where American troops are operating.

It is intended that no one eligible for release will be held in the Army because there are men with higher scores overseas who have not been returned home. Eligible men will be discharged as rapidly as they can be processed for separation.

No enlisted personnel with a sufficient number of critical points will be kept because of "military necessity" except those very few men classified in one of three essential technical skills. These are: Orthopedic me-

chanics, electroencephalographers who operate electrocardiac equipment and radio transmitter attendants. The latter is not in the Medical Department.

#### **A.M.A. Washington Letter of September 24:**

#### **Army Mismanagement of Medical Manpower Charged**

Col. W. Paul Holbrook, testifying before the Senate Military Affairs Committee as an investigator to survey army medical needs, said that too few doctors had been used by the Army at the front and too many behind it. He claimed that the armed forces had taken 60,000 doctors for the 12,000,000 men in uniform and had left only 90,000 at home to care for 120,000,000 civilians. He declared that there were too many doctors for service personnel and that determining the number of physicians required on the numerical strength of units was a "fundamental fallacy" of the army system. Colonel Holbrook said that 50 doctors assigned to a 15,000 man infantry division were "far too many for preventive medicine to healthy young men, yet far too few on the field of battle." Despite this, he pointed out, this number of doctors was assigned to a division whether or not it was at the front or in an inactive theater.

\* \* \*

#### **More Hospitals and Doctors Required by Veterans Administration**

Veterans Administration officials are now checking on additional hospital and medical personnel needs of the agency, expected to be heavy as increasing numbers of servicemen are discharged. General Omar N. Bradley, new veterans administrator, with Major Gen. Paul R. Hawley, acting Veterans Administration Surgeon General, and Brig. Gen. H. B. Lewis, acting director of organization, and other aides, conferred at Atlanta, Ga., with agency officials from eight Southeastern states.

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#### **Navy to Release 1,678 Reserve Medical Officers**

Vice Admiral Ross T. McIntire, Surgeon General of the Navy, informed the Senate Military Affairs Committee that the Navy would release 1,678 of its 12,000 reserve medical officers under the point system by January 1. He explained that they will be released at the rate of 880 a month, starting January 1, and that 8,000 will be out by the time the Navy reaches its postwar goal of 550,000 officers and men next September 1. An effort will be made to keep medical discharges up to the pace of demobilization of fighting personnel.

#### **Professional Training Planned for Army Doctors**

In order to provide qualified doctors for the peacetime, Army plans have been formulated to interest Medical Corps officers who are serving for the duration of the war to apply for commission in the Regular Army, Major General Norman T. Kirk, Surgeon General of the Army, announced recently.

Among the more important attractions which will be offered Medical Corps officers who remain in the Army are the following:

1. The Regular Army Medical Corps officer will be assured a professional career offering broader possibilities in a larger field than the practice of the average civilian doctor affords.
2. The training and the assignments of Army doctors will be arranged to aid the Army doctors in obtaining board certification for specialties from the recognized civilian specialty boards.
3. Graduate training will be continued with the estab-

lishment of Army fellowships, residencies and special courses.

In addition to the above attractions, which carry decided weight with any professional man, the Army affords security in its pension system, hospitalization care and other considerations not usually available in civilian practice, General Kirk said.

Civilian practice on the whole involves considerable uncertainty, and the locality in which a man has established himself and other factors seriously limit the scope of the practice a doctor can engage in, General Kirk said.

This program which is being inaugurated is designed to obtain and utilize to the best advantages the professional skill now available in the Army, according to Colonel Floyd L. Wergeland, Director of the Training Division of the Surgeon General's Office, and Chairman of the committee handling the professional training of Army doctors.

The plans under this policy call for the establishment of graduate training programs at Army Installations where the residencies will meet the requirements of specialty boards and arrangements will be made for accrediting by the appropriate specialty boards, Colonel Wergeland said. Another phase of the program includes the establishment of Army internships at selected Army general hospitals.

Plans outline a procedure for giving professional rehabilitation and specialized training to Regular Army Medical Corps officers who have been in administrative work during the war. These doctors who have not been able to engage in practice because of administrative responsibilities will serve as understudies with doctors who have been active in professional practice. This assignment will lead to continued professional service and eventually specialty board certification.

Medical Corps officers in the Regular Army will be kept in professional capacities without material interruption under this plan.

The advantages of a professional career in the Army will also be brought to the attention of medical students to interest them in an Army commission. Only those who stand scholastically in the upper third of their classes will be prevailed upon to consider the Army for a career.

Reserve or AUS officers now on active duty who desire consideration for commission in the Regular Army may forward through channels Statement of Interest to War Department Adjutant General's Office in accordance with the provisions of War Department Circular 243.

Civilian physicians and former Organized Reserve Corps and AUS officers now on inactive duty status may submit Statement of Interest direct to the Adjutant General's Office.

Future announcements as to securing commission in Regular Army Medical Department will be publicized in current professional and military publications.

### Hospitals Named for Refresher Training Courses

On September 10, 1945, the Surgeon General notified the Commanding Officers of the following hospitals that their medical services had been approved for the professional refresher training of Medical Corps officers to extend over a twelve week period:

Cushing General Hospital, Framingham, Massachusetts  
Mason General Hospital, Brentwood, Long Island, New York  
Valley Forge General Hospital, Phoenixville, Pennsylvania  
Kennedy General Hospital, Memphis, Tennessee  
Newton D. Baker General Hospital, Martinsburg, West Virginia

Percy Jones General Hospital, Fort Custer, Michigan  
Winter General Hospital, Topeka, Kansas  
McCloskey General Hospital, Temple, Texas  
*DeWitt General Hospital, Auburn, California*

Medical Corps officers desiring refresher training in neuropsychiatry will be permitted to serve the entire twelve weeks on the neuropsychiatric services and to rotate through the various wards of the neuropsychiatric services in order to gain experience in all phases of neuropsychiatry.

The refresher course will follow Guide for Professional Refresher Training for Medical Corps Officers approved by SPTRU 353 (Med.) (Nov. 13, 1944), dated November 17, 1944.

### General Rankin in Talk on Work of Army Surgeons

A major factor in the Army's record of saving the lives of almost 97 out of every 100 wounded men who reached a hospital was the quality of surgical care given these soldiers, Brigadier General Fred W. Rankin, Chief Consultant in Surgery of the Army Medical Department, told the graduating class of ASTP and V-12 students at the University of Michigan School of Medicine on September 15 at Ann Arbor, Michigan.

The lowered mortality rate in this war also was achieved because the highly qualified surgeons did their work without loss of time and also because hospital facilities staffed by specialists were placed near the front.

General Rankin said the average wounded man received his initial surgery at an evacuation hospital within ten hours of the time of his injury.

"In carefully selected cases," General Rankin added, "in which surgery was done at field hospitals the average time lapse was considerably less."

The efficient operation of the Army chain of evacuation made this possible. It starts at the time a man is wounded, and it is usually only a matter of a few minutes before the Medical Corpsman gives emergency treatment.

General Rankin explained that the Army's accomplishments were possible partly because of the method of assigning qualified specialists and also to the dissemination of information through the Consultants Division as to the best methods to be used under certain circumstances.

"The general principles of wound management were two-fold; initial debridement and delayed wound closure," the General continued. "The use of this method in the Mediterranean Theater of Operations resulted in primary healing in 95 per cent of the cases in which it was used and was attended with no loss of life or limb and with no serious complications."

Improved techniques reversed the ratio of deaths and survivals in abdominal injuries as compared with that of the last war. About 60 per cent of the casualties in the last war were fatal, while in this war 60 per cent of such casualties survived.

The so-called early nerve suture resulted in regeneration in 85 per cent of the cases in this war, according to the General. Another notable accomplishment in this war has been the reduction in the mortality rate in the dangerous cases, or the head, chest and abdomen wounds, which is only half as high as during the last war.

Reconstructive and rehabilitative surgery designed to correct the disfiguring consequences of battle wounds is achieving results "that can fairly be termed miraculous," General Rankin said.

### Neuropsychiatric Discharges in Army Now Total 315,000

The nation's total of soldiers who have been discharged from the Army for neuropsychiatric reasons has now reached 315,000, Brigadier General Williams C. Men-



ninger, Director of the Neuropsychiatry Consultants Division of the Army Medical Department, said in a recent (October 8) talk before the New York Academy of Medicine.

Describing this problem as a "postwar challenge to medicine," General Menninger expressed the hope that "physicians will prepare themselves to accept and treat what the Army medical officers discovered were among their biggest problems—the emotional factors in the production of illness."

"With this understanding on the part of the physician," General Menninger said, "treatment must be directed towards integrating the individual into his pre-war identifications and satisfactions."

On the basis of the Army's experience with neuropsychiatric cases, which are referred to as combat exhaustion or combat fatigue, only about 3 to 5 per cent of the soldiers suffered reactions due entirely to fatigue. The condition of the great majority was primarily a personality disturbance and treated as such, he explained.

Upon induction into the Army a soldier faces an entirely different life which in certain cases produces sufficient stress in the individual to bring him to the psychiatric breaking point.

"Frustration," he pointed out, "was a daily part of the soldier's life, sometimes in the form of waiting days, weeks, months, sometimes in the deprivation of essential supplies.

"Confusion was routine in his life and the noise and whistles and flares of battle are beyond the imagination of anyone who has not heard and seen them."

General Menninger said that essentially the response is the same when an individual fails to adjust himself to his situation in civilian life as it is when he finds he cannot meet the demands of Army life.

### Age of American Military Leaders

When Nazi Germany unleashed its fateful blitzkrieg in Europe six years ago, the Regular Army of the United States comprised less than 200,000 men under the leadership of about 100 Generals.

By the time Germany capitulated early in May of this year, our Army, including the Air Forces, numbered well over 8,000,000, and when the surrender of Japan brought the war to a close in mid-August, the total in this service was not very appreciably smaller. The top leadership during the war period had increased to more than 1,500 Generals.

On July 1, 1945, there were 1,539 Generals in our Army, and their average age was 51.4 years. Almost 35 per cent of the Generals were under 50 years of age, a slightly higher proportion were concentrated in the age group 50 to 54, while an additional 20 per cent were in the age period 55 to 59; 8 per cent were 60 to 64, and less than 2 per cent were 65 years or over.

At the lower end of the list of Generals are the Brigadier Generals who constitute 70 per cent of the total number; their average age on July 1st was 50.3 years, or ten years below that for the Generals of the Army and five years below the average for Lieutenant Generals.

### Army Medical Conference at Auburn

More than 160 medical men from all branches of the armed forces in the Ninth Service Command met on September 14-15, at DeWitt General Hospital in Auburn, California, for an intensive two-day program of study.

In addition to medical discussions and illustrated movies, the doctors made ward rounds to see at first hand illustrations of topics in the following hospital sections: Vascular, neurosurgical, orthopedic, dermatology and paraplegic.

### Mollycoddling of Wounded Found Ruinous for Morale

The staff of Birmingham General Hospital at Van Nuys in Los Angeles County, on August 27, found their policy of "no sympathy" for wounded veterans upheld by the Army's surgeon general, Maj. Gen. Norman T. Kirk.

"Mollycoddling of wounded war veterans will ruin their morale and turn them into sympathy-seeking bums," General Kirk said. "I saw it after the first world war and it almost made me cry."

He added "There is a high standard of morale among the wounded veterans of this war which, if untampered with by mistaken people, will carry them through an independent postwar life.

"We will find them well able to look after themselves as long as they are not made to feel that they are a burden," he said.

Birmingham Hospital has been training and educating war casualties in every phase of useful civilian life—from gainful employment and new professions to their mental attitude toward civilians.

The Surgeon General praised the work of the medical services which, he said, had brought the overall death rate down to approximately 3 per cent. He attributed the low death rate from wounds to a "combination of factors including quicker attention to wounded men on the battlefield, faster evacuation, outstanding surgery, equipment and hospitalization."

With 300,000 wounded men in hospitals in this country and all casualties from the Pacific expected home within 90 days for treatment an average of five and a half months, General Kirk reemphasized that doctors are still sorely needed for the medical corps.

He said the medical men will not be released as rapidly as the combat veterans.

### Veteran Suffers

On the question of government-sponsored medical care, too much emphasis has been placed on the doctors versus the government. In between are the people, and they are the ones who stand to gain or lose the most. As more than one doctor has pointed out, if State medicine is thrust upon the medical profession and the doctors don't like it, those who wish can escape by merely switching to some other line of business. But for the people, there is no escape. If State medicine is adopted and results in lowered medical standards there will be nothing the people can do about it—socialism is a one-way road. The people will be socialized, not the doctors.

The medical profession opposes State medicine because it has studied the lessons of history and knows that too much government in medicine will not bring adequate medical care to all the people. A tragic example of State medicine can be seen in the veterans' hospitals. Many veterans are getting worse than poor medical care all because their treatment is swamped in red tape—politics takes precedent over the requirements of good medicine. And who has suffered the consequences, the veteran or the doctor? Ask the veteran!—San Francisco *Underwriter's Report*, August 9.

### Civilian Psychiatrists Report on Army Neuropsychiatric Work

The commission of outstanding civilian psychiatrists appointed by the Office of Scientific Research and Development at the suggestion of the Surgeon General for a study of the Army's neuropsychiatric work overseas reported that as a result of prompt and skilled handling of combat exhaustion cases approximately 90 per cent of these men are returned to duty, Colonel William C.

Menninger, Director of Neuropsychiatry Consultants Division of the Office of the Surgeon General, has announced.

Members of the commission at a recent meeting in the Office of the Surgeon General were generous in their praise of the exceptionally fine psychiatric work that is being accomplished in the European Theater of Operations where they visited for eleven weeks, Colonel Menninger said.

Combat exhaustion cases, known as shell shock in the last war and sometimes referred to as combat fatigue or operational fatigue, are being treated more successfully in this war because of the high quality of personnel in the field, better methods and techniques, and of the greatest importance is the fact that our psychiatrists are getting to the men sooner than ever before, according to the findings of the commission. The Army psychiatrists are doing some of their most effective work right up near the front at the clearing stations.

There is some variation in the treatment given. Sedation, narco-synthesis, hypnosis, and the new technique of group psychotherapy were some of the methods of handling these battle-weary soldiers. The results of group psychotherapy were, in general, particularly encouraging.

Dr. Menninger brought out the fact that an alert and understanding sergeant or lieutenant can anticipate a case of combat exhaustion. Symptoms are increasing irritability, lack of interest in letters from friends or family, lack of interest in comrades, and the throwing away of equipment and food. A man who has reached this stage, but who has not yet come to the breaking point can usually be brought back to normal with the help of a proper rotation plan to give the necessary rest and relief from the stress of battle.

There is a direct ratio between the number of exhaustion cases and the intensity of combat, Dr. Whitehorn pointed out. The number of combat exhaustion cases is almost always just about one-fifth the number of wounded cases.

Every man has his breaking point, according to psychiatrists. It is just a matter of how much stress and strain is put upon a man and for how long a period. The fact that combat exhaustion cases bear a direct ratio to the number of wounded shows that as the battle becomes more intense the pressure is just that much heavier, causing more men to reach the breaking point.

A factor that leads to combat exhaustion is the martyr situation, Dr. Whitehorn said. When men are unavoidably marooned from the main body of troops so that the situation seems hopeless, or when they are on a mission which they do not understand and which seems futile or when they are isolated and lose their leader, the average man is more likely to become subject to combat exhaustion under such circumstances.

The commission's report will stress the fact that combat exhaustion does not mean that a man is "yellow," or a coward. A big percentage of the combat exhaustion cases represent men who have had long months of service at the front as effective and brave fighting men. They simply come to the point where the human system can take no more. It is then that the psychiatrists start to care for the ailing soldier.

This commission will submit a formal report of its findings to the Office of Scientific Research and Development, Dr. Bartemeier announced.

#### **Total Streptomycin Production Only Fourteen Ounces a Month**

The War Department recently said that streptomycin, the new wonder sister drug to penicillin, was being used in 30 Army general hospitals over the country, but that

it was so difficult to obtain that the total output of the four companies now making it has been only 14 ounces a month.

Major General Norman T. Kirk, Surgeon General of the Army, said the Army was receiving many requests for the drug for use in treatment of urinary and other infections caused by gram-negative bacteria which do not respond to penicillin, but that these cannot be met since the Army neither controls the supply nor can get enough for its own needs in treatment of battle-wounded soldiers.

General Kirk said that the four companies, Merck, Upjohn, Abbott and Squibb were the principal manufacturers of the new product, but that other concerns were working at experimental production at pilot plants and that any civilian request for streptomycin naturally would go to these companies.

"The Army and Navy are purchasing only a part of available production," General Kirk said. "In August, 28 ounces—or 800,000,000 units—were purchased. Joint Army-Navy expectations for September are 162 ounces, but it is anticipated that production will be not more than 70 ounces. It is hoped that Army-Navy procurement can be doubled in October—for military needs alone now are about 2,000 ounces a month."

A gram, or 1,000,000 units is the standard daily dose administered in three injections over a twenty-four hour period.

Production is limited severely because the drug is obtained from a natural fungus found in the soil and must be grown under carefully controlled laboratory conditions which cannot be hurried.

The phenomenal production of penicillin which brought it from a laboratory curiosity to a commonly-used drug and the price from astronomical figures to about a dollar a dose was due in part to pressure of wartime needs, the General pointed out.

"But," he added, "with the war ended and priorities a thing of the past, streptomycin does not have these advantages, thus working to some extent to hamper production, although industry is doing what it can do supply the demand."

General Kirk explained that the Army's principal needs are for treatment of soldiers with severed spinal cords who develop urinary tract infections because of a loss of bladder function, and to some extent in treating some cases of meningitis and other infections which do not respond readily to penicillin therapy.

**Military Clippings.**—Some news items of a military nature from the daily press follow:

#### **Two-Front War Cost U. S. 252,885 Lives Lost and \$287,181,000,000**

Washington, Sept. 1. (AP).—European and Pacific combat casualties—both Army and Navy—included 252,885 killed, 651,218 wounded, 43,969 missing and 122,747 prisoners.

There were 17,300 surgical amputations; 7,300 men were deafened to some degree; 1,190 were blinded in one or both eyes.

The war cost us a total of \$287,181,000,000, compared with \$280,000,000,000 spent by Germany, \$49,154,000,000 by Japan and \$135,856,000,000 by Russia, our nearest allied competitor in the spending line.

\$119,000,000,000 Taxes

Americans coughed up \$119,346,228,000 in taxes during wartime. War-developed Treasury indebtedness will hit \$208,226,445,700 with War Bond subscriptions and all other securities.

We lend-leased \$39,000,000,000 in supplies of all kinds to our allies.

Agriculture produced \$20,000,000,000 in food for the armed forces, lend-lease and foreign relief. Even with agricultural manpower reduced by military calls, production reached a peak increase of 35 per cent over the pre-war level.



The war effort meant a \$20,300,000,000 expansion in the country's manufacturing facilities—more than 13,000 facility additions—with the major share of the costs coming from public financing.

#### Loss by Strikes

A peak of 10,300,000 workers was reached for the munitions industry alone—approximately one munition-maker for every manjack in our more than 11,000,000-strong Army and Navy.

With 14,070 labor strikes between Pearl Harbor and the end of July, 1945, the cost in mandays was 34,787,000, one-tenth of one per cent of all available working time.

#### Last Year's Production

As we entered the final year of war the U. S. was producing 45 per cent of the world's munitions. We had raised our synthetic rubber production from 8,000 tons in 1941 to 753,000 tons in 1944, trebled our aluminum output from 1942 to 1944, increased production of aluminum 50-fold in five years.

Our Navy was built up to a two-ocean armada of more than 100,000 vessels of all sizes, including 1,500 fighting ships—a fleet larger than the combined navies of the rest of the world. Just before the war ended the Navy reported we had lost a total of 431 "naval vessels."

American shipyards produced about 60,000,000 deadweight tons of merchant ships, and we lost about 7,000,000 tons.

As for airplanes: From December, 1942, to VJ-Day, 223,444 aircraft of all types were produced—from tiny trainer planes to B-29's—and the figure includes 184,433 tactical craft.

#### Shoes to Locomotives

Also the Army alone procured:

Tanks, armored cars and self-propelled vehicles—119,400.  
Artillery pieces of all types—1,116,000.  
Small arms—18,900,000.  
Tractors, bulldozers and other construction equipment—180,000.  
Trucks—2,400,000 (including 660,000 jeeps).  
Radio sets of all types—1,700,000.  
Telephones—2,660,000.  
Tents—29,000,000 (which includes "shelter-halves" or two-piece pup tents).  
Shoes—117,000,000 pairs.  
Locomotives—7,000.

We reached a peak of supplying 625,000 tons of paper-board a quarter to the armed forces for the packaging of thousands of items from foods to munitions.

#### Regulation by O.P.A.

Amid blackouts and brownouts, car-sharing and bundle-hauling, citizens saw O.P.A. price regulations applied to some 8,000,000 articles and services. They learned to get along under the rationing of the most essential items for living except clothing—and hustled down to the blood-donor center to give a total of 13,300,000 pints.

The nation's railroads handled some 32,000,000 Army troops in organized movements and 287,000,000 tons of Army freight.—Los Angeles Times, September 2.

#### Japanese Military Vital Statistics

Government reports to the Japanese Diet on September 5, disclosed that Japan claims to have suffered only 656,278 casualties in dead, wounded and missing during the war, according to incomplete figures.

Included in this figure are 40,000 army personnel who died from illness out of 4,470,000 listed as "sick," which raised the total casualties to 5,086,278. The army was reported to have lost 310,000 killed, 146,000 wounded and 4,470,000 sick, of which 40,000 died. The navy reported 157,365 killed, 1,430 dead from sickness and 1,483 missing.

Other reports said that the single atomic bombs dropped on Hiroshima and Nagasaki had made those cities the second and third hardest hit in the Japanese home islands, with Tokyo, pounded by months of Superfortress fire attacks and carried plane raids, the most heavily damaged.

Tokyo lost 149,556 killed and wounded, Hiroshima lost 108,760, and Nagasaki prefecture lost 130,000. Total air raid casualties in the home islands were 554,350, including 211,309 killed and 313,041 wounded, and the destruction of 2,333,388 homes making 8,045,094 people homeless. Of these 2,578,150 were made homeless in Tokyo.—San Francisco Chronicle, September 7.

#### Says Army Doctors Not Fully Utilized

Washington, Sept. 13—(AP).—A War Department spokesman told Senators today that the Army had not fully utilized the services of its physicians.

The testimony by Colonel W. Paul Holbrook, a doctor

and a member of the War Department general staff, promptly brought from Senator Downey (D., Calif.) the comment that there had been "a vast and unwarranted waste of medical service" during the war.

Colonel Holbrook appeared at the Senate military committee's hearing on demobilization to tell of a special study of Army use of doctors, dentists and nurses which he made for the committee.

He testified that some 17,000 doctors will be returned to civilian status before January 1.

He explained that Army doctors were assigned much like firemen, whereas they should have been used only in emergencies. For example, he said the average division had fifty doctors, or one doctor for 300 men—"far too many for simple medical care."

At the same time, he said, this was "too few" doctors for Army units that faced heavy casualties.

As Senators listened intently, the witness said that the Army and Navy had taken some 62,000 doctors for armed forces, leaving only 90,000 physicians for the civilian population. He said this resulted in slightly more than six doctors for every 1,000 men in military services and left only one civilian doctor for every 1,500 civilians.—San Francisco Call-Bulletin, September 18.

#### Another Revision of Army Scores

Washington, Sept. 23—(UP).—The Army tonight announced new screening scores which will exempt an additional 300,000 officers and men from overseas service...

For Medical Officers, the requirements for exemption are as follows:

Male officers, Medical Corps and Dental Corps, 45 points or 40 years of age; male officers, Veterinary Corps and Medical Administrative Corps, 30 points or 35 years of age; nurses, 12 points or 30 years of age; Medical Department dietitians and physical therapy aides, 18 points or 30 years of age.

As announced previously, members of the Women's Army Corps will not be shipped overseas.

The new regulations do not apply to members of the Regular Army or to men who have volunteered for overseas service...

This is the first time exemption scores have been computed for officers.

It was disclosed meanwhile that the Office of War Mobilization and Reconversion has been trying without success to get the Navy to demobilize its men at a faster rate. A high OWMR official said that recent informal efforts to persuade the Navy have been unavailing, but that OWMR is still trying...

Answering congressional criticism that many men are being kept in needlessly and that some are performing petty, unnecessary duties, he reaffirmed a pledge that the Army will not keep any man in uniform longer than absolutely necessary.

The OWMR spokesman said his agency is dissatisfied with the manner in which the Navy is demobilizing. He said there are "too many men now sitting around in the Navy doing nothing." No specific rate of discharge was requested.

The Navy's schedule calls for the release of 3,000,000 by September 1, 1946, leaving 50,000 officers and 500,000 enlisted men as the nucleus for its peacetime strength. Present plans call for releasing 764,000 enlisted men and 75,000 officers by Christmas. The rate of discharge is to be increased each month so that by the end of this year the Navy will have 2,390,000 enlisted men and 253,800 officers.

An Army spokesman said over the week end that the War Department will review its demands for peacetime military training if and when results confirm its belief that voluntary recruiting will not provide an adequate armed force. The Army will want a force of some 1,000,000 officers and men, he said, and is convinced that voluntary recruiting will not bring that many.—San Francisco Chronicle, September 23.

*Lane's Kink.*—Treatment of chronic intestinal stasis by short-circuiting the intestine was originally described by W. Arbuthnot Lane in an article entitled, "Chronic Constipation: A Consideration of its Surgical Treatment." Lane is also noted for his work on the treatment of fractures by plates and screws. A prominent British surgeon, he wrote a manual on operative surgery, and during the last war he figured importantly in the administration of surgical service.—Warner's *Calendar of Medical History.*

## COMMITTEE ON MEDICAL ECONOMICS

### A Kansas Opinion of Mr. Kaiser's National Health Plan

*A Medical Editor's analysis of Mr. Henry Kaiser's article as guest editor for Mr. Drew Pearson's "Washington Merry Go Round."*

Recently Henry Kaiser, as guest editorialist for Drew Pearson, gave a glib solution for all medical-care mal-distributions: Get ten G-I medics together, pool their \$2,500 apiece, pyramid this with a \$25,000 bank-loan to build a hospital-clinic and presto—we would have "many little Mayo Clinics" throughout our land. Just like that all difficulties are dissolved. Of course, the sustained financial support of these mushroom institutions is to be contingent on widespread prepayment plans.

His intriguing prospectus would be breath-taking in its broadness of concept and simplicity of design if it were not for a few obvious "bugs" in the syllogism. His major premise is that ten G-I medicos can get together and function as a unit, not rarely and uniquely, but that this coalition would occur generally and commonly throughout the land. In the first place no ten medicos—G-I or otherwise—have ever been known to agree so thoroughly and completely as to cast their entire future and fortune into a common lot except with some form of compulsion. There is something basically and inherently in the training or development of a physician which usually makes him a supreme individualist. He will not pull for long in the same harness with nine (or even two or three) other medicos unless under pressure.

Therefore, Mr. Kaiser's major premise (or first guess) is unsound. Who gets whom together—to form ten men, tried and true? In what town do they settle for this cozy, communal life? Who picks whom for the "captain" of this ten-man ball team? Who becomes what specialist? Which doctor drives the biggest car; on what side of the square do they build this "clinic"? Who gets the biggest "cut" of the financial melon? These are simple, every-day problems which have split asunder more so-called "clinics" in the past than Uncle Henry's production-line techniques ever will produce in the future!

His minor premise involves prepaid costs. Supposing it is a rural area these ten men (if they do agree) have finally decided to honor with their "little Mayo Clinic." Where is the "check-off" system so familiar to Mr. Kaiser? Even our local Blue Cross or other such voluntary pre-payment systems must depend—for their very blood and bone—on a large, pay-roll deduction type of contribution to be really successful. Do you find this in a town of two or three thousand persons? Who actually collects the prepayment monies; who supervises the services rendered (no one is foolish enough to think citizens will just throw so much per capita at this budding "clinic" with no strings attached); what central agency polices the contributor that he does not abuse the system?

Easy, ain't it, Uncle Henry? But as "Doctor" Ordway (the Crime Doctor) says: "There is just one little detail" you have forgotten! When physicians speak of the Mayo Clinic, they do so proudly and somewhat collectively. They also mean the Lahey Clinic, the Crile Clinic, and a few others of a like, superior quality. As you speak of it, Mr. Kaiser, it would seem that merely throwing together a bunch of bricks and cement—and a bunch of doctor men, would constitute a "clinic." On paper it may, but this is not a physician's idea of a *real clinic*. This takes "that one little detail," not from the production-line or drafting-board, Mr. Kaiser. It takes a man—or a few men—with drive and vision, more than

just a dandy dream or an idle idea. It requires the ability to *lead*, someone with such strength of purpose that he can *command* a group.

Already there are thousands of "clinics" throughout the United States. They are as real as the penny postcard replicas of a masterpiece. So in this pretty picture you have painted, Mr. Kaiser, do not forget "that one little detail," without which these thousands of "little Mayo Clinics" will be as empty, as worthless and as useless as burnt-out light bulbs. Oh, Mr. Kaiser!—Vincent Williams, M.D., Editor, Jackson County Medical Society *Bulletin*, Kansas City, Mo.

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

### President Truman's Message to Congress

On September 6th, President Truman sent a message to Congress outlining a twenty-one-point legislative program.

The following excerpts relating to public health and medical service activities have received press association comment:

For carrying on scientific research and development, the President asked Congress to set up a single federal research agency to promote and support research in basic sciences, social sciences, medicine, public health and allied fields. This agency would aid in all projects pertaining to defense and security and make available to commerce and industry the fruits of government financed research.

The President said he soon would ask Congress for a national health program to provide "adequate medical care for all Americans and to protect them from financial loss and hardships resulting from illness and accident."

He also promised a communication with respect to "expanding our social security system, and improving our program of education for our citizens."

For veterans, the President urged that Congress should revise the G. I. bill of rights along the lines of recommendations made by the Veterans' Administration. These include liberalizing hospital and medical care, national service life insurance, and educational and vocational training.

Apropos of the above, and indicating the extent to which Labor groups maintain an interest in plans for socialized medicine through national supervision, it may be of interest for physicians to note what was stated in the *News Letter* of the "Northern California Union Health Committee" of September 15th. Excerpts follow:

### President to Recommend National Health Program:

President Truman in his message to Congress recently emphasized the necessity for expanding the present social security program, including provisions for national health. The President impressed upon Congress the urgency of legislation that will provide more adequate unemployment benefits, but added that a special message setting forth recommendations for a national health program providing "adequate medical care for all Americans" was forthcoming. Although pressures from the A.M.A. and other opponents of compulsory health insurance are already being exerted upon the President, if the voice of organized labor and other friends of national health insur-



ance is sufficiently strong, the President may recommend the comprehensive and forthright program outlined in the Wagner-Murray-Dingell bill.

Attached to the above *News Letter* was a full page display pink slip which read as follows:

#### *Action! For Social Security*

Write or wire President Truman today. Tell him:

1. That you or your organization welcomed his statement on the importance of expanding social security.
2. That you or your organization will support his forthcoming recommendations for a national health program.
3. That you or your organization favors the forthright and comprehensive program for national health outlined in the Wagner-Murray-Dingell bill.

The A.M.A. and other opponents of compulsory health insurance are already exerting their pressure upon the President. Let us win this fight!

#### **Murray-Wagner-Dingell Bill**

The *Sacramento Bee* of September 11th contained a statement by the Democratic State Central Committee, outlining ten points that had been devised by a legislative subcommittee of which John Anson Ford of Los Angeles is chairman.

Item 9 therein contained the following recommendation:

A memorial to Congress to pass the Murray-Wagner-Dingell bill for public health facilities and the extension of public assistance programs.

## COMMITTEE ON POSTGRADUATE ACTIVITIES

### **Wartime Graduate Medical Meetings**

Note.—The C.M.A. Postgraduate Committee presents below the roster of speakers and topics of "Wartime Graduate Medical Meetings." These listings may have suggestive value to program committees of Component County Societies.

#### **CLINICS, DEMONSTRATIONS, LECTURES**

Under the Auspices of the American Medical Association, the American College of Physicians, the American College of Surgeons  
Authorized by the Surgeons General,

Norman T. Kirk, Ross T. McIntire, Thomas Parran

#### *Committee 24th Zone*

Lt. Comdr. Geo. C. Griffith (MC), USNR, Chairman

U. S. Naval Hospital, Corona

Capt. Harry P. Schenck (MC), USNR

Wayland A. Morrison, M.D.

James F. Churchill, M.D.

Program of the Wartime Graduate Medical meetings for Zone 24 (Southern California) follow:

*Birmingham General Hospital—3:00 P.M.*

October 10—"Recent Developments in Surgical and Public Health Antisepsis"—Dr. Fred J. Moore, Prof. of Bacteriology, U.S.C.

October 24—"Communicable Diseases"—Major Norman Nixon

"Acute Infectious Mononucleosis"—Capt. Chas. H. Marple

*Camp Haan, ASF Regional Hospital—3:30 P.M.*

October 2—"Neuro-Psychiatry"—Lt. Comdr. Nichols

*March Field, AAF Regional Station Hospital—3:30 P.M.*

October 16—"Tumor Pathology"—Dr. Edward Butt

*Camp Cooke Station Hospital—1:00 P.M.*

October 3—"Recent Developments in Diabetes"—Dr.

Howard F. West

October 17—"Traumatic Surgery of the Urinary Tract"

—Capt. D. W. Atcheson

*Hoff General Hospital—8:00 P.M.*

Same programs given at 1:00 P.M. at Camp Cooke

Station Hospital repeated here at 8:00 P.M.

*Torney General Hospital—3:30 P.M.*

October 2—"Cardiac Pain"—Capt. Arthur A. Twiss

October 16—"Acute Nephritis"—Prof. Lytle, Prof. of Pediatrics, U.S.C.

*U. S. Naval Hospital, Santa Margarita Ranch—1:00 P.M.*

October 11—"Penicillin in the Treatment of Syphilis and Gonorrhea"—Lt. Comdr. W. W. Duemling

October 25—"Neuro-surgery"—Capt. Everett Dickinson.

*U. S. Naval Hospital, Long Beach—3:00 P.M.*

October 17—"The Streptococcal Problem"—Lt. Comdr. Geo. R. Underwood

*U. S. Naval Hospital, Corona—1:00 P.M.*

October 11—"Burns"—Capt. H. T. D. Kirkbaum

October 25—"False Biological Reactions"—Major Mark Beam

"Allergies"—Major Iredell Hinnant

*U. S. Naval Air Training Station, San Diego—3:00 P.M.*

October 5—"Acute Infectious Hepatitis"—Col. Irving Wright

October 19—"Psychosomatic Medicine"—Major Milton Miller

"Headache"—Capt. Oscar Sugar

*Santa Ana Army Air Base—3:30 P.M.*

*A.A.F. Regional and Convalescent Hospital*

October 2—"The Streptococcal Problem"—Lt. Comdr. Geo. R. Underwood

October 18—"Endocrinology"—Dr. Hans Lissner

*U. S. Naval Hospital, San Diego—1:00 P.M.*

October 4—"Peripheral Vascular Problems"—Col. Irving Wright

*U. S. Regional Hospital, Pasadena—7:00 P.M.*

October 8—"Thoracic Surgery"—Comdr. W. L. Rogers

### **California Heart Association**

The Sixteenth Annual Postgraduate Symposium on Heart Disease will be held in San Francisco on October 17, 18, 19, and 20, 1945.

Visiting guest speakers include:

*Samuel A. Levine, M.D.*, of Boston, is one of the country's foremost cardiologists, and one of our most beloved and respected teachers. He is the author of "Clinical Heart Disease," a popular and widely used textbook.

*Colonel Irving S. Wright, MC*, Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons, is now Consultant in Medicine, Headquarters, Ninth Service Command, Fort Douglas, Utah. He is a national authority on peripheral vascular disease.

*Louis E. Martin, M.D.*, of Los Angeles, Assistant Clinical Professor of Medicine, University of Southern California School of Medicine is President of the California Heart Association. As Chief of the Cardiac Clinic of the Children's Hospital in Los Angeles he has had wide experience with rheumatic fever.

*James J. Waring, M.D.*, of Denver, Colorado, is Professor of Medicine at the University of Colorado School of Medicine. He is a member of the American Board of Internal Medicine, and a former President of the Board of Directors of the National Tuberculosis Association. Program follows:

WEDNESDAY AFTERNOON—OCTOBER 17, 1945

1:30 P.M.-5:00 P.M.

University of California Hospital—Toland Hall

Third and Parnassus Avenues

*Sessions on Rheumatic Fever*

Sponsored by the American Academy of Pediatrics,  
Northern California

Crawford Bost, M.D., Chairman for Northern California,  
American Academy of Pediatrics, Presiding

1:30 P.M.

The Importance of Early Diagnosis in Rheumatic Fever

Louis E. Martin, M.D., President California Heart  
Association

2:15 P.M.

Rheumatic Fever: A Military Problem—Lt. Comdr.

Harold Rosenblum, MC, U.S.N.R.

2:50 P.M.

Recess

3:00 P.M.

Clinical Demonstrations of Various Manifestations of  
Rheumatic Fever—Peter Cohen, M.D., Presiding  
Participants

Helen M. Johnson, M.D., Medical Director, Cardiac Pro-  
gram, Crippled Children's Services, California State  
Department of Health

Mary B. Olney, M.D., Assistant Clinical Professor of  
Pediatrics, University of California Medical School  
and Director of the Children's Cardiac Clinic, Uni-  
versity of California Hospital

Alice Potter, M.D., Assistant Clinical Professor of  
Pediatrics, University of California Medical School,  
and Acting Supervisor, Cardiac Diagnostic Center of  
the San Francisco Department of Public Health

4:15 P.M.

General Discussion—Questions and Answers

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THURSDAY MORNING—OCTOBER 18, 1945

9:30 A.M.—12:00 Noon

Stanford University Medical School

Stanford Hospital, Lane Hall

Sacramento Street, Near Webster

Arthur Selzer, M.D., Presiding

9:30 A.M.

The Importance of Diaphragmatic Hernia in the Dif-  
ferential Diagnosis of Coronary Artery Disease—

Walter Beckh, M.D.

10:00 A.M.

Recent Trends in Electrocardiography—

Arthur Selzer, M.D.

10:30 A.M.

Actions of Digitalis—David A. Rytand, M.D.

11:00 A.M.

Recess

11:10 A.M.

Some Notes Concerning Cardiac Murmurs—

Samuel A. Levine, M.D.

12:10—1:30 P.M.

Box luncheons will be available in the auditorium  
of the Nurses' Home, 2340 Clay Street

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THURSDAY AFTERNOON—OCTOBER 18, 1945

1:30—5:00 P.M.

Stanford University Medical School

Stanford Hospital—Lane Hall

J. Marion Read, M.D., Presiding

1:30 P.M.

Clinical Pathological Conference—Samuel A.  
Levine, M.D. and Alvin Cox, M.D.

2:30 P.M.

Problems in Penicillin Treatment of Subacute Bacterial  
Endocarditis—Arthur L. Bloomfield, M.D.

3:00 P.M.

Importance of Myocardial Infarction in Subacute  
Bacterial Endocarditis—Clarence Tinsley, M.D.

3:30 P.M.

Pathological Results in Bacterial Endocarditis Treated  
with Penicillin—William H. Carnes, M.D.

4:00 P.M.

The Present Status of Anti-Coagulants in the Treatment  
of Cardiovascular Disease—Col. Irving S. Wright, MC

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FRIDAY MORNING—OCTOBER 19, 1945

9:00 A.M.—12:00 Noon

University of California Hospital—Toland Hall

Third and Parnassus Avenues

Leslie L. Bennett, M.D., Presiding

9:00 A.M.

Obstruction of the Aorta—with Presentation of Cases—  
William J. Kerr, M.D.

9:30 A.M.

Heart Disease in Soldiers—Gordon E. Hein, M.D.

10:00 A.M.

Tuberculosis and Heart Disease—James J. Waring, M.D.

10:30 A.M.

Recess

10:40 A.M.

Smithwick Splanchnicectomy in the Treatment of  
Hypertension: Comparison with the Peet Procedure

Howard C. Naffziger, M.D., and

Francis L. Chamberlain, M.D.

11:10 A.M.

Differential Diagnosis of Neurovascular Syndromes of  
the Shoulder Girdle—Col. Irving S. Wright, MC

12:00 M.—1:30 P.M.

Box luncheons will be available in Room 100 of the  
Pharmacy Building—Parnassus and First Avenues

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FRIDAY AFTERNOON—OCTOBER 19, 1945

University of California Hospital—Toland Hall

William J. Kerr, Presiding

1:30 P.M.

The Surgical Risk of Heart Disease—

William H. Gordon, M.D.

2:10 P.M.

Atypical Angina—Eliot Sorsky, M.D.

2:50 P.M.

Demonstration of Electrocardiograms of Autopsied  
Patients—Francis L. Chamberlain, M.D.

3:50 P.M.

Recess

4:00 P.M.

General Discussion—Questions and Answers—  
Samuel A. Levine, M.D.

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FRIDAY EVENING—OCTOBER 19, 1945

7:00 P.M.

Sixteenth Annual Dinner Meeting

Colonial Ballroom—St. Francis Hotel

David A. Rytand, M.D., Chairman, Presiding

The Treatment of Congestive Heart Failure—

Samuel A. Levine, M.D.

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SATURDAY MORNING—OCTOBER 20, 1945

9:00 A.M.—12:00 Noon

San Francisco Hospital

Potrero Avenue and Twenty-second Street

Report at Main Entrance of Hospital and Proceed to



Solarium of Ward 2  
Charles A. Noble, Jr., M.D. and  
Clarence M. Tinsley, M.D., Presiding  
Clinical Demonstrations of Various Types of  
Heart Disease

### University of California School of Public Health

The School of Public Health of the University of California has announced the appointment of four new faculty members. Dr. W. McDowell Hammon became Associate Professor of Epidemiology in the School of Public Health. He will be responsible for developing the training programs in epidemiology, and will continue to serve the University as Associate Professor of Epidemiology in Hooper Foundation.

Dr. Richard A. Bolt has been appointed Visiting Professor in Public Health. Dr. Bolt has been one of the leaders in the development of the child hygiene movement in America. Recently he retired as Director of the Cleveland Child Health Association and as a member of the faculty of the Department of Public Health and Pediatrics at Western Reserve University.

Dr. Clair E. Turner, formerly professor of biology and public health at Massachusetts Institute of Technology, and recently chief health education officer of the Coördinator of Inter-American Affairs, has been appointed Visiting Professor of Health Education and will begin his duties with the opening of the autumn semester.

Mr. Walter S. Mangold has been appointed Associate Professor of Sanitary Practice. Mr. Mangold is nationally known as a consultant in the field of Sanitary practice. He will be responsible for the development of the post-war program for training sanitarians in the School of Public Health.

For announcement of the School of Public Health of the University of California, Walter H. Brown, M.D., Acting Dean, address: U. C. School of Public Health, 3583 Life Sciences Building, Berkeley, California.

### Medical Films Available for Component County Medical Societies of C.M.A.

The Committee on Postgraduate Activities of the California Medical Association has purchased 17 medical films. List of titles and time to run appears below.

Letters giving information concerning procedure for use of these films have been sent to the presidents and secretaries of all C.M.A. county societies.

The films are also available for branch or specialist sections of larger county units.

Films will be serviced and kept in good condition by Castle Distributors Corporation, 943 Russ Building, San Francisco.

Requests for films should be sent to C.M.A. Postgraduate Committee, c/o George H. Kress, M.D., Secretary, 450 Sutter Street, Room 2004, San Francisco (8).

All films are "silents," that is, with explanatory legends. List follows:

Filing Number of Film	Title of Film	Running Time Single Film	Total Time for Sequence
1—Acute Appendicitis (Professional)			
	Reel I	15 Min.	} 2 Reels 31 Min.
2—Acute Appendicitis (Professional)	Reel II	16 Min.	
	* * *		
3—Benign Prostatic Hypertrophy		17 Min.	
	* * *		
4—Cardiac Irregularities—Reel I		17 Min.	} 2 Reels 34 Min.
5—Cardiac Irregularities—Reel II		17 Min.	
	* * *		
6—Infections of the Hand—Reel I		17 Min.	} 3 Reels 48 Min.
7—Infections of the Hand—Reel II		17 Min.	
8—Infections of the Hand—Reel III		14 Min.	

9—Indirect Inguinal Hernia—Reel I	16 Min.	} 3 Reels 41 Min.
10—Indirect Inguinal Hernia—Reel II	10 Min.	
11—Indirect Inguinal Hernia—Reel III	15 Min.	
	* * *	
12—Intestinal Peristalsis	16 Min.	
13—Normal Heart	10 Min.	
14—Rabies	8 Min.	
15—Simple Goiter	17 Min.	
	* * *	
16—Treatment of Normal Breech		
Presentation—Reel I	15 Min.	} 2 Reels 29 Min.
17—Treatment of Normal Breech		
Presentation—Reel II	14 Min.	

## COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

### Health Lecture Series to Physicians and Public Opened on Friday, October 12

The fall public relations program of the Los Angeles County Medical Association opened with a series of public health talks to be presented in the Lodge Room of the Elks Temple, at 607 South Park View Street, Los Angeles, on Friday evening, October 12, at 8 o'clock. The program for the six meetings to be held on consecutive Friday nights appears below:

#### PROGRAMS—HEALTH LECTURE SERIES

*PLACE: Lodge Room, Elks Temple, 607 South Park View  
Friday Evening, October 12, at 8:00 p.m.*

#### "PENICILLIN—THE LIFE SAVING MIRACLE"

1. Address of Welcome... Jay J. Crane, M.D., President, Los Angeles County Medical Association.
2. Introduction of Doctors George H. Uhl and H. O. Swartout, City and County Health Officers.
3. Three Addresses on Penicillin by
  - a. J. Norton Nichols, M.D.
  - b. James C. Doyle, M.D.
  - c. Paul M. Hamilton, M.D.

*Friday Evening, October 19, at 8:00 p.m.*

#### THE TRUTH ABOUT VENEREAL DISEASES

1. Education and Venereal Diseases... Mr. David Eli Janison, Director, Public Health Information, Los Angeles City Department of Health.
2. The Venereal Diseases... E. M. Fainer, M.D., Director Men's Venereal Disease Clinic, Los Angeles City Department of Health.
3. Venereal Disease Control Highlights... Herbert H. Cowper, M.D., Director, Venereal Disease Control Division, Los Angeles City Department of Health.

*Friday Evening, October 26, at 8:00 p.m.*

#### PREVENTIVE MEDICINE

1. Industrial Health... Hugh Dierker, M.D., Los Angeles County Health Department.
2. Disease Problems in a War-Torn World... Norman B. Nelson, M.D., Director, Division of Communicable Diseases, Los Angeles City Department of Health.
3. Tuberculosis, Cancer and Heart Disease...

*Friday Evening, November 2, at 8:00 p.m.*

#### MODERN SURGERY—Three Addresses by

E. Vincent Askey, M.D.  
(Speaker to be Announced Later)  
L. A. Alesen, M.D.

#### FIRST HUNDRED YEARS OF ANESTHESIA

*Friday Evening, November 9, at 8:00 p.m.*

#### GIFTS OF MODERN MEDICINE

1. The Story of Medicine and Its Place Today... Paul A. Quaintance, M.D.
2. Medical Specialties... T. T. Remmen, M.D.
3. The Female Hormones... Clifford A. Wright, M.D.

*Friday Evening, November 16, at 8:00 p.m.*

#### BLESSED EVENTS

1. What Price Baby?... William Benbow Thompson, M.D.
2. New Baby Health Insurance... Harold K. Marshall, M.D.
3. Why a Cesarean Section?... Donald G. Tollefson, M.D.

The Los Angeles County Committee on Public Relations and the Executive Committee began working on this series of talks early in the summer. The City and County Health Departments are coöperating in making these programs of real value to the people of this area.

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Shortly after plans for the series got under way, the Council of the California Medical Association was approached with the thought that if these programs could be put on in the various component county medical associations throughout the State the same evenings they were being presented in Los Angeles a very well worth while cumulative result in public relations would be obtained. The Council of the California Medical Association accepted this proposal and county medical associations in California are being asked to present similar programs.

The Los Angeles County Medical Association has sent to the California Medical Association sufficient mimeographed copies of all talks to be presented in Los Angeles, these talks to be of suggestive value to the officers of the various county associations in the arranging of their programs.

State-wide publicity will be achieved by the Public Relations Department of the California Medical Association to insure good audiences. The publicity program here in Los Angeles, which will be supported by the State publicity, will depend very largely upon members of the Association and members of the Woman's Auxiliary. Publicity also will be obtained via the radio and by means of newspaper publicity. The newspaper publicity campaign will be greatly augmented by the Public Health Educational Division of the Los Angeles City Health Department.

\* \* \*

Members of the Association are now asked to inform their patients of this series of public health lectures and to tell their friends and acquaintances about it. Members are asked to spread the word of this public health program in every way they possibly can.

Remember, the series opens on Friday evening, October 12, at 8:00 o'clock, in the big Lodge Room of the Elks Temple, 607 South Park View. Of course, there is no admission charge. Everyone interested is cordially invited. Members are invited to come with their friends.

The subjects selected for the six evenings were given a great deal of consideration. Especially considered was the interest of the public in these subjects. The talks will be largely augmented by illustrations and motion pictures.

A great deal of work has gone into this public relations endeavor. Its real success now depends to a great extent upon each member in spreading the word about it. You will be safe in telling your friends and patients that these talks will not only be highly educational but exceedingly interesting. Tell them not to be reticent in inviting their friends to come with them. Everyone is welcome.

### Facts on Use of DDT

#### *An Insecticide, with Toxic Properties*

Since the proper use of DDT requires special knowledge and training, a bulletin has been published as a technical guide for the Army to its safe and efficient use, Major General Norman T. Kirk, Surgeon General of the Army, recently announced. The publication contains information on the precautions to be taken in handling DDT, its mode of action in insect control, and the proper methods of application of the DDT insecticide items issued by the Army.

It is emphasized that, although DDT may be safely handled as an insecticide, it is, nevertheless, a toxic material. Poisoning may occur from ingestion of DDT or by absorption of DDT solutions through the skin. DDT powder and aerosols are not absorbed through the skin, and have been found to produce no ill effects when inhaled in small amounts. However, in conditions where air currents do not carry away the dust from the user, it is wise to wear suitable respirators as protection against excessive inhalation.

DDT acts on insects both as a contact poison and as a stomach poison. Studies have shown that the poisonous effect of DDT on mosquito larvae is fully as powerful as that on the adult insect, although on some other insects, such as flies, the larvae are not equally affected by the insecticide. In applying DDT as a mosquito larvicide to open water receptacles, a prolonged effect may be obtained because of the residual action of the chemical. However, in applying it to natural water bodies the effect is much shorter, due to the binding action of mud in the water, which apparently checks the effectiveness of DDT. It should also be considered that amounts of DDT greater than 0.2 pound per acre may prove fatal to fish and wild life. For extermination of insects such as ants, roaches, fleas, bedbugs and flies, DDT oil solution or powder should be used, with particular attention to cracks, holes, and seams in walls, floors, and bedding, as indicated. One of the most valuable characteristics of DDT lies in its tendency to remain deadly to insects over a prolonged period of time. In applying DDT solutions to walls and other large surface areas, a coarse spray is usually employed, but in applying it to screens or mesh surfaces, ordinary paint brushes may be used. Although the effectiveness of the treated areas against insects persists for some time, the insects which come in contact with the chemical may not die until an hour or more has elapsed, and immediate death should not be expected.

When applying solutions of DDT in kerosene, precautions concerning the inflammability of the kerosene should be observed. Care should be taken to keep electric motors and other sparking or heating apparatus from the zone of spray. No open fires or smoking should be permitted until the spray has dried and ventilation is complete. The kerosene in the solution is harmful to rubber equipment and may cause a mild skin irritation when in contact with the skin.

Thanks to the magic properties of DDT, many lives have been saved in this war and much disease prevented. Extermination of disease-carrying insects has reduced the incidence of typhus, malaria, and other ravaging diseases of the war areas.

Although rapid progress has been made in the development of DDT since it first made its appearance in the field of science, much remains to be learned before its full potentialities in insect control can be realized. Signs of progress are evident in the spraying of large areas by aircraft, the mass delousing of communities in Europe, and the better methods of manufacture. Investigation is continuing on every aspect of DDT, however, in search of new and extensive improvements in everything from its chemical beginning to its final application in the field.

### Improvement in Health of the Nation

Improvement in the health of the nation sufficient to save many thousands of lives annually is seen as probable for the early postwar years by the medical men in the life insurance business, the Institute of Life Insurance recently announced.

"General application to the population as a whole of the many revolutionary discoveries of the war period, up



to now largely used for members of the armed forces, is expected to be an important factor contributing to the reduction of mortality," the Institute reported. "In addition, the extension of medical research on a greater scale should hasten the discovery of controls in certain diseases which remain as major causes of the country's deaths."

Among the wartime health discoveries or activities which may benefit the population as a whole in the future are: revolutionary use of blood plasma; discovery of penicillin; extension of the use of the sulfa drugs; DDT for control of germ bearing insects; military research on both curative and preventive medicine; successful inoculation against typhus; new advances in plastic surgery; use of mobile x-ray, operating, optical and dental units; uses of blood's by-products such as red corpuscle transfusions for anemia, fibrin film as substitute brain covering, serum albumin for wound shock, fibrin's foam as a blood-clotter in nerve surgery, fibrin's use as a glue in skin-grafting, use of red corpuscles to paint wounds and reduce inflammation.

These are only a few of the many surgery and drug discoveries which have contributed to reducing the death rate of wounded to 3 per cent in the present army, compared with 8.1 per cent in World War I. At the same time, the Army death rate from disease has been reduced to one-third that of civilians of the same group types, in spite of the greater hazards among the military, especially in overseas service.

The extent to which health progress can be made is indicated by the experience among life insurance policyholders over the past fifteen years. The three-year average death rate among civilian policyholders for the years 1942-1944 is about 20 per cent lower than the three-year average for 1927-1929. "The significance of this progress becomes clear when translated to policyholder lives saved per year," the Institute continued. "It would indicate, for instance, that in 1945, barring unforeseen circumstances, there should be 100,000 fewer civilian policyholder deaths than there would have been had the death rate of fifteen years ago still applied. Going back to 1900, we find that 1945 will probably see at least 350,000 fewer civilian policyholder deaths than would have occurred under the death rate of 45 years ago.

About 75 per cent of all the savings in lives since 1929 has been accounted for by just the reduction in death rate from tuberculosis, typhoid, influenza and pneumonia. The ravages of these four diseases alone have been so checked by the intensive efforts of recent years that in 1945 they will probably cause at least 75,000 fewer deaths among policyholders than they would on the basis of 1929 death rates. The reductions in the annual death rates from the 1927-29 level to the 1942-44 level were as follows: tuberculosis, 55 per cent; typhoid, 90 per cent; influenza, 80 per cent; pneumonia, 60 per cent.

Great strides have also been made in the reduction of deaths among children. The infant death rate has been cut in half in the same fifteen-year period and deaths from the children's diseases of diphtheria, whooping cough, scarlet fever and measles have been reduced to almost one-tenth the 1929 rate.

### Life Expectancy

One of the larger life insurance companies reports the wartime and the prewar period—so far as overall conditions are concerned—were beneficial to the health of American United States civilians.

Despite restrictions involving curtailed diet, unfavorable housing conditions, lack of normal medical facilities and similar emergency factors, the life expectancy of company policyholders was 64.40 years at the beginning of 1945 as against a full year less in 1941.

The expectation of life of the insured group, based on mortality records, also was a half year shorter in 1943 than last year.

The comparisons exclude military and civilian deaths caused by enemy action, of course, but they emphasize two points. As the insurance company statisticians explain, wartime hardships

have not been severe enough to offset the advantages secured by the high standards of living in the prior years of peace (and) not all our people have undergone these hardships—a goodly number actually have been able to advance their standard of life as a result of widespread full employment.

### Dr. Parran Maps Six Point Health Program for All Citizens

A six point program to provide "equal health opportunities for every citizen" was outlined by Surgeon General Thomas Parran of the U. S. Public Health Service at the 122nd opening session of George Washington University School of Medicine. He was guest of honor at a luncheon given by Dr. Walter A. Bloedorn, dean of the school, at the Mayflower, attended by Army, Navy and District medical leaders. Dr. Parran's program called for

(1) an integrated system of hospitals and health centers radiating from a central unit to smaller local and rural communities;

(2) sanitary environment, covering water, milk, food and sewage, which would eradicate such diseases as malaria;

(3) intensified preventive disease programs, including expanded cancer control, dental, nutrition and nursing programs;

(4) expanded medical research;

(5) training of engineers, nurses, technicians and research workers, as well as doctors, to man postwar health armies;

(6) health insurance and medical care, as provided in such legislation as the Wagner-Murray-Dingell bill and the Miller bill. Dr. Parran said that 121 bills coming up in the 79th Congress would cover his six point program.—*A.M.A. Washington Letter.*

### Randolph Health Bill for Federal Employees Considered Again

The House Rules Committee has cleared the way for consideration on the House floor of the Randolph health bill for government employees. An hour's debate was ordered. The health bill, sponsored by Representative Jennings Randolph, Democrat of West Virginia, provides for setting up employee health program, including clinics in various government departments, at the direction of department heads. It would be part of a general program, to promote physical and mental fitness of government employees such as is now carried out by a large number of business organizations.

### Basal Temperature Records to Aid Infertility Treatment

A basal temperature record to aid in determining the probable time of ovulation in individual women is being made available by the Medical Committee of the Planned Parenthood Federation of America to physicians interested in the treatment of infertility and the planning of conception.

As reported by Dr. Pendleton Tompkins in the issue of March 11, 1944, of the *Journal of the American Medical Association* (Vol. 124:697-700), it has been found

that an accurate daily record of basal temperature is valuable in estimating the optimum time for conception.

There is a slight rhythm of variation in the normal temperature of a healthy woman—the temperature being lower during the first half of the menstrual cycle than during the later half. The transition from the lower level to the higher one occurs at about the time of ovulation. In many cases the temperature will show a sharp drop and then shoot immediately to the higher level which can be taken as an indication that ovulation is taking place. As the variation for the entire cycle may be less than half a degree, the patient must be provided with complete instructions and forms with which to plot her temperature accurately. The temperature is taken rectally each morning immediately upon awaking before the patient has gotten out of bed, talked, eaten, drunk or smoked.

The charts, as provided by the Planned Parenthood Federation, provide for a six months' record. They indicate the calendar months, the length of the individual cycle and the number of days backward from the onset of the menses at which ovulation can be estimated to occur.

The charts, together with the instruction forms for patient use, are available at cost through the Medical Department, Planned Parenthood Federation of America, Inc., 501 Madison Avenue, New York 22, N. Y.

### Conclusions From a Study of 7 Million Births

From a study of the live births and stillbirths of more than 7,000,000 American babies in the five years from 1937 to 1941, came important evidence in support of the child-spacing theory. This is the now commonly held medical opinion that each mother needs a period of rest and recuperation between the birth of one child and the beginning of another pregnancy.

Dr. Jacob Yerushalmy, principal statistician in the United States Public Health Service, has found that the amount of time between pregnancies has an important relationship to the possibility that reproduction will end in the tragedy of a stillbirth. More than 75,000 American babies are lost each year through stillbirths.

Precisely how long the average space between births should be to reduce the danger of stillbirth to a minimum, Dr. Yerushalmy was unable to indicate from his findings. He did conclude, however, that "relatively short intervals (between pregnancies) and relatively long intervals are associated with higher stillbirth rates while moderate intervals lead to the lowest rates."

The results of his study appeared in detail in the last issue of *Human Biology*.

### Victory Over Disease

One highly significant statement was that recently from Army Medical Corps sources to the effect that, for the first time in the history of war in Europe, more men were admitted to American theater hospitals for treatment of battle wounds than for diseases. The same fortunate situation seems to have existed in the Pacific as well.

The amazing record for the American forces doubtless has been due, in some degree, to the fact that Uncle Sam's fighting men, taken as a whole, were the healthiest ever to be sent into battle.

But, beyond any question, the most important factors were the safeguards taken to protect the health of our soldiers and sailors. Never in any war has any nation given such vigorous and intelligent attention to the prevention of diseases—particularly germ diseases of the type which have little or no respect for natural resistance. This was a protection provided through such expedients as destruction of vermin and the provision of opportunity

for uncontaminated drinking water. No one knows how many men were saved from sickness or death through such measures, but certainly the number totaled in the many, many thousands.

And, if war can be productive of blessings, the experience gained in the prevention and treatment of diseases surely is one of them. It is a blessing which will be with us in peace, as well as in war. It undoubtedly will mean longer and healthier lives for people today and for all generations to come. It represents a victory no less important than any gained upon the fields of battle.

### On Venereal Disease Control

A "chaotic condition" for control of venereal disease recently was predicted for San Francisco during the next one and one-half years.

Dr. Richard A. Koch, chief of the city's venereal diseases division, said that with the lifting of strict wartime measures which kept the control program just holding the line for the past four years, the number of cases would no doubt far exceed the 700-a-month now being treated, at least until the city settles down to a peacetime status.

He said he feared the results of an increasing concentration of Army and Navy personnel in this area who would be "out for a good time" now the war was over and military and Federal social welfare supervision relaxed. The consequences of the three-day victory "celebration" would also mean a sharp rise in venereal disease, he was sure.

Dr. Koch quoted the report of Dr. Carl Buck of the American Medical Association, who made an independent survey of San Francisco's postwar health program. Dr. Buck said he "hoped San Francisco would not make the fatal mistake of so many communities after the last World War in abandoning or curtailing venereal disease control services.

Dr. Buck has recommended that San Francisco's "present program of venereal disease control be continued as a necessary means of preventing the personal and economic losses which would otherwise result."

Records kept by the department of health on venereal disease from before Pearl Harbor show an average of 206 total (military and civilian) cases a month in February, 1941, which climbed steadily until it is now in 1945, over the 700-a-month mark.

While military cases have shown a decided increase over these years, the incidence of the diseases among civilians has remained fairly steady. By the end of 1944 there were only 30 more cases being found a month among civilians.

### 6,000 Wartime Cases

A total of more than 6,000 cases were turned up during the war years in San Francisco among military and civilians.

Dr. Koch lists the contributing factors in the increased venereal disease load as:

1. The large increase in civilian population, particularly population groups with high v.d. rates.
2. The large increase in military population.
3. Increased social and moral problems created by war.
4. Better case reporting from the military and civilian treatment agencies as well as from private physicians.
5. Broad v.d. education and case-finding programs have increased public awareness for proper medical treatment and decreased "quack" practices.
6. Increased staff of Public Health nurses and male investigator for infectious case follow-up.

With the help of the Health Department and the Social Hygiene Association there is at the present time a social



awareness of the venereal disease hazard in industry which didn't exist three years ago.

In the last 14 months the San Francisco Health Department has done 34,054 blood tests on local industrial workers; 3,354 of these workers were found to have a positive blood test—and 80 per cent of these had syphilis, with 50 per cent of them unaware of their infection, Dr. Koch said.

### Federal Appropriations For VD Control and Social Protection

Passage on June 30 of the Labor-Federal Security Appropriations Bill (H.R. 3199, now Public Law 124, 79th Congress) for the fiscal year ending June 30, 1946, and approval by President Harry S. Truman on July 3, assures continuance for the eighth consecutive year of Federal aid to states for VD control through the U. S. Public Health Service, and continues for its fifth year the Social Protection Division of the Federal Security Agency.

The appropriation to U. S. Public Health Service for the coming year, to carry out the purposes of the La-Follette-Bulwinkle VD Control Act of 1938, including aid to states, is \$11,949,000. The decrease from the approximate \$12,500,000 for each of the past three years is accounted for primarily by reduction in overtime pay, in accordance with recent Congressional action; by reduction in personnel in unclassified positions who have been taken over by the states and put on state payrolls; and the lower cost of penicillin.

The Rapid Treatment Center program, formerly administered Federally by the Federal Works Agency, is turned over to the USPHS by this Bill; and \$4,644,000 is provided for maintenance and operation.

### Venereal Disease Facts—Los Angeles City

1. Estimates based on current attack rates indicate that there exist in Los Angeles 72,520 individuals who now have or have had syphilis. This is a minimum figure.

2. There is a good possibility that there exists an equal number of persons who have syphilis but have no knowledge of their disease. Of the 72,520 who are presumably unaware of their infection, 18,000 are potential candidates for brain, spinal cord, or cardiac syphilis.

3. A child born in Los Angeles City and living under current conditions, has a better than 1 in 15 chance of acquiring syphilis before he attains the age of 45. This again is a minimum figure based on actual reported cases and adjusted for age, race, and sex.

4. The attack rate for syphilis in the city was 65 in 1943, and 101.6 in 1944.

5. The attack rate for gonorrhea was 265 in 1943, and 374 in 1944.

6. In 1944 there were 1,142 reported cases of new venereal disease infections in the 15-to-19-years age group. This represents a 28 per cent increase over 1943.

7. The venereal disease attack rate in the 15-to-19 age group, based on reported cases, has increased 120 per cent since 1939.

8. In 1944 the attack rate for syphilis in the State of California was 50; in Los Angeles City it was 101.6.

9. A total of 40.8 per cent of all syphilis and 30 per cent of all gonorrhea reports in California originate in Los Angeles City.

10. So far in 1945, 11,666 cases of venereal disease have been reported in this city.

11. The syphilis rate, in infants under 1 year of age, per 1,000 live births increased from 0.52 in 1943 to 1.12 in 1944.

It would be of interest to have similar statistics for other cities in California.

### Care of the Eyes

The Health Committee of the Chamber of Commerce of the United States, Washington, D. C., through its Health Advisory Council, recently sent out the following bulletin on "Do's and Don'ts" for eye health:

Do provide proper lighting—without shadows or glare—in the home, school, office, and shop—to avoid eye strain.

Do rest the eyes occasionally by closing them or by looking at distant objects.

Do protect the eyes of infants from exposure to direct sunlight or bright artificial light, and from toys with points or sharp edges.

Do have your child's eyes examined before he enters school and regularly thereafter.

Do have your own eyes examined regularly.

Do consult a competent specialist regarding correction of eye defects, including muscle imbalance, squint, cross eyes, nearsightedness, farsightedness, and blurred vision, and for injured, painful, sore, or diseased eyes.

Do protect your eyes with a shield or goggles of good quality if you work where your eyes are exposed to electric arc rays or sparks, to splashing chemicals, or to flying particles of dust, sand, or metal.

Do not rub your eyes with fingers or soiled handkerchiefs—to do so may rub germs into your eyes.

Do not use towels or wash cloths used by others—they may cause serious eye infections and blindness.

Do not wear colored glasses unless you need them under special circumstances; do not wear colored glasses of inferior quality under any circumstances.

Do not try to diagnose or treat your own eye troubles, and do not wear glasses already made up and sold or displayed on store counters.

Call a doctor immediately if simple measures fail to remove a foreign body in the eye; do not rub the eye—to do so may drive the foreign body deeper into the tissues of the eye and damage or infect the eye.

To remove foreign body, grasp lashes of upper lid and pull down over lower lid and then release so that tears may wash foreign body to inside corner of eye where it can be removed easily with corner of sterile bandage—or flush the eye thoroughly with clean, cool water.

Chemicals in the eyes, such as acids, caustics, lime, plaster, cement, etc., should be washed down the eye immediately with very large and repeated quantities of clean cool water before the doctor comes.

### Texas Sets Insurance Plan Principles

Six Principles adopted by the Council on Medical Economics of the State Medical Association of Texas, for guidance in the evaluation of plans and policies offered in the distribution of medical and surgical service:

1. Insurance companies should be solvent.

2. Nonprofit Insurance companies shall be as nearly nonprofit as is consistent with sound business principles and practices.

3. Insurance companies should avoid advising subscribers to consult any certain doctor or doctors. In general policies should conform to the usages of medical ethics, and specifically there should be free choice of doctors, and no interference with the traditional doctor and patient relationship.

4. Insurance companies should cause to be stated on the face of their policies that the amount allowed in the policy for medical care does not necessarily cover the charges of the doctor for his services.

5. Insurance companies should not provide payments to any hospital, or hospitals for the services rendered the insured by any doctor.

6. It should be recognized that insurance companies are at the present time forced to feel their way in hospital and sickness insurance, and that changes in plans and procedures may be necessary for several years.

*Robert Burns (1759-1796).*—Privation, exposure, and overwork in adolescence predisposed Robert Burns to rheumatic infection and endocarditis. At one time, undertaking a self-cure for spells of dizziness, he kept a tub of cold water beside his bed into which he would plunge when faint. There are those who would attribute his early death to alcoholism, but many find it difficult to believe that the imperishable songs and ballads of this most beloved of Scottish poets are compatible with a life of dissipation.—Warner's *Calendar of Medical History*.

## MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

### NEWS

#### Coming Meetings†

*California Medical Association.* Session will convene in Los Angeles. Dates of the seventy-fifth annual session, to be held in 1946, will be announced later.

*American Medical Association.* The A.M.A. House of Delegates will convene in Chicago, Dec. 3-6, 1945. (See J.A.M.A., Sept. 22, 1945.)

#### The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments or principles included in the A.M.A. platform appear in CALIFORNIA AND WESTERN MEDICINE for December, 1939, on pages 394-395. For subsequent comment, see J.A.M.A., June 24, 1944, pp. 574-576. See also C. AND W. M. for August, 1945, pp. 61-62.)

#### Medical Broadcasts\*

*The Los Angeles County Medical Association:*

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a.m., under the title, "Your Doctor and You."

In August, KFAC will present these broadcasts on the following Saturdays: August 4, 11, 18, and 25.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

\* County societies giving medical broadcasts are requested to send information as soon as arranged.

#### Pharmacological Items of Potential Interest to Clinicians:

1. *Where now, Big Boy?* The *New Yorker*, as usual avoiding cliches, does well on atomic energy, especially with profile of N. Y. Timesman W. L. Laurence, stimulating science writer (*New Yorker*, Aug. 18, p. 26). Psychology of surrender is well discussed by T. Draper in August *Atlantic*, p. 62. For atomic energy, the fundamental equation is Einstein's  $E = mc^2$ , where  $c$  is the velocity of light ( $3 \times 10^{10}$  cm/sec) (*The Meaning of Relativity*, 2nd Ed., 1945, 135 pp., Princeton Press, \$2). And for this brave new world there is also J. von Neumann and Morgenstern's *Theory of Games and Economic Behavior* (Princeton Press, 1945, 644 pp., \$10), and G. Polya's *How to Solve It* (Princeton Press, 1945, 220 pp., \$2.50).

2. *Symposia and Reviews:* S. Warren, B. E. Hall & Co. give neat symposium on radioactive phosphorus in leukemia and polycythemia (*Am. J. Med. Sci.*, 209:707-717, 1945). Note abstract symposium on effects of centrifugal force on animals and man (*J. Physiol.*, 104: Proc. 5-12, June, 1945). Neuropsychiatry symposium (*Brit. Med. Bull.*, 3:1-64, 1945), contains F. M. R. Walshe's account of Queen Square neurology classics and D. Williams clinical application of electroencephalography. Also note symposium on wound healing, burns and shock (*Brit. Med. Bull.*, 3:70-119, 1945). C. B. Friedman reviews pathology of trench foot (*Am. J. Path.*, 21:387, 1945). B. H. Kean and R. G. Grocott review sarcosporidiosis (*Am. J. Path.*, 21:467, 1945). W. J. Tompkinson reviews chronic toxoplasmosis (*J. Clin. Path.*, 15:123, 1945). E. J. Conway analyses physiological significance of inorganic ions in internal medium of mammals (*Biol. Rev. Cambridge Philo. Soc.*, 20:56, 1945). J. Sinclair calls attention to helpful symposium on genes as physiological agents (*Am. Naturalist*, 29:289-363, 1945). G. Wald reviews human vision and the spectrum (*Science*, 101:653, June 29, 1945). P. Levine reviews Hr factor and Rh genetic theory (*Ibid.*, 102:1, July 6, 1945). R. F. Pitts reviews renal regulation of acid base balance (*Ibid.*, 102:54, 81, July 20 and 27, 1945). And *Annual Reviews and Physiological Reviews* continue well: J. H. Burn discusses epinephrin and acetylcholin in nervous system; H. F. Blum surveys sunlight effects, and H. N. Harkins reviews burns (*Physiol. Rev.*, 25:377, 483, 531, 1945).

3. *Therapeutics:* R. A. Peters & Co. find cysteine and methionine useful in recovery from postarsphenamine jaundice (*Quart. J. Med.*, 14 ns: 35, 1945). F. Proescher's acridine-sulfa compounds are finally exploited as wound antiseptics by J. McIntosh & Co. (*Lancet*, 2:97, July 28, 1945). A. M. da Cunha & Co. find penicillin effective in yaws (*Mem. Inst. Oswaldo Cruz.*, 41:247, 1945). C. P. G. Wakerley and G. Blum (Berlin M.D.), find UFI, compound of urea and iodine, is helpful when powdered on wounds (*Lancet*, 2:42, July 14, 1945). A. Meyer and D. Teare report case of fat embolism following electrical convulsion therapy (*BMJ*, 2:43, July 14, 1945). F. Himmelweit notes bacteriophage aid in antibiotic action of penicillin against resistant organisms (*Lancet*, 2:104, July 28, 1945). G. C. Linder suggests

\* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.



blood phosphatase as index to dosage of estrogen in prostatic disease (*Clin. Proc., Cape Town P.G. Med. Assn.*, 4:64, 1945). H. F. Shaw indicates value of approach to therapeutics through mode of action of drugs on cells in Blakian style (*Med. J. Austral.*, 1:649, June 30, 1945). V. P. Filatov reports on tissue therapy in cutaneous leishmaniasis (*Am. Rev. Sov. Med.*, 2:484, 1945).

4. *Odds and:* C. Sutherland offers evidence that household allergen is polysaccharide (*Med. J. Austral.*, 1:583, June 9, 1945). J. Muniz and G. de Freitas report successful complement fixation diagnostic test for Chagas disease (*Mem. Inst. Oswaldo Cruz*, 41:303, 1944). S. Rose and D. Rabinov report experimental success of electrical anesthesia (*Med. J. Austral.*, 1:657, June 30, 1945). S. Sarkisov (Moscow Brain Inst.), discusses new developments in brain morphophysiology (*Brit. Med. J.*, 2:37, July 14, 1945). W. Feldberg and T. Mann (*J. Physiol.*, 104:8, 1945), confirm D. Nachmansohn and A. L. Machado (*J. Neurophysiol.*, 6:397, 1945), that brain synthesizes acetylcholine anaerobically in presence of adenosinetriphosphate and choline, and add that reduced glutathione and cysteine strongly activate aerobic formation, with inhibition by sugars and Ca, and stimulation by K. E. C. Dodds & Co. (*J. Physiol.*, 104:47-51, 1945), fail to confirm H. G. Wolff & Co. (*J. Clin. Invest.*, 20:63, 1941), that morphine raises pain threshold to heat in man, and report no significant analgesia from diphenylethylamine, although it gives incoordination. B. Benesch shows synthesis of nicotinic acid in human caecum under aerobic conditions and destruction under anaerobic (*Lancet*, 1:718, June 9, 1945).

P.S. B. de Voto's comments on University of Texas in August *Harper's* derive from H. P. Rainey; like those in *PM* and *Collier's* they are neither inclusive nor conclusive.

**Two-thirds of San Francisco War Chest for Health Welfare.**—Two-thirds of the \$3,950,000 sought in the San Francisco War Chest October drive will go to local health and welfare agencies.

Seventy hospitals, clinics, youth agencies, children's institutions and homes for the aged-ill are scheduled to receive \$2,432,003.

Of the remainder \$831,428 would go to the U.S.O. and the United Seamen's Service and \$531,569 to 16 national and international war relief agencies.

#### State Bar to Aid Military Veteran Attorneys.

More than 2,500 lawyer veterans will be assisted in returning to their civilian practices by the State Bar of California, which has organized a placement service, refresher courses, advisory and welcoming committees.

Judge Roger Traynor, Leigh Atherne, Thomas H. Kennedy, Eugene M. Prince and Joseph C. Sharp of San Francisco, and Harold Huovinen of Oakland have been appointed members of a committee in charge of the placement service headed by Chairman Herbert Freston of Los Angeles.

Dean Edwin J. Owens and John H. Riordan are San Francisco members of the educational committee which has planned a series of lectures to be given in the San Francisco-Sacramento and Los Angeles-San Diego metropolitan areas.

#### Examination for Chief, Bureau of Tuberculosis.

The duration examination for Chief, California Bureau of Tuberculosis, originally scheduled for September 13, 1945, has been postponed to November 22, 1945. The final date for filing applications has been extended to November 8, 1945.

In accordance with the provisions of Section 18901 of the Government Code, any list of eligibles resulting from

this examination "will expire not less than one but less than four years after adoption of such list." The State Personnel Board may remove all names from such eligible lists at any time after they have remained thereon for more than one year from the date of adoption and will remove all names from such lists not later than four years after adoption.

This examination is a *duration* examination, held under Section 19200 of the Government Code to provide a duration open eligible list. Eligibility resulting from this examination and appointments made from the resulting eligible list will expire not later than 90 days after the Governor finds and proclaims that the present emergency no longer exists. However, employment under duration appointments will count toward seniority, sick leave, and vacation credits and will constitute qualifying experience for entrance to examinations when appropriate.

**Goldschmidt Writes Book on Mutation.**—Sudden hereditary changes, mutations—which produce offspring different from any of their ancestors, are caused by stresses inside the germ cell which result in rearrangements of the chromatin, nuclear material of the cell. This belief, supported by voluminous genetic data, is embodied in a volume by Dr. Richard Goldschmidt, authority on genetics, and professor of zoology on the Berkeley campus of the University of California.

His book, *A Study of Spontaneous Mutation*, was published by the University of California Press. It contains data on thousands of fruit fly matings in a series of experiments which have been carried on continuously for the last ten years.

Dr. Goldschmidt speaks of spontaneous mutation as the most important phenomenon of genetics, because he says the theory of heredity, as well as that of evolution, is based completely upon it. He indicates that this work throws light on the causes of mutation in nature, about which little is known.

"The general trend of these data is to suggest that mutation is not a haphazard event in a so-called gene molecule," Dr. Goldschmidt says, "but a phenomenon of a determinate, orderly type which is caused by conditions within the chromosome."

#### Milk Company Profits Less Than 1/3c a Quart.

Profits of milk companies have been less than one-third of a cent a quart—.3 of a cent to be exact—according to an Indiana University Bureau of Business Research nationwide study of milk distribution costs.

The cost of raw milk delivered to the plant along with the wages and salaries of workers took nearly 82 cents of each sales dollar.

Expenditures for plant, delivery, and office supplies and services required 7.28 cents of each dollar of sales, while taxes, insurance and depreciation accounted for 5.96 cents of each dollar received by the milk distributors.

Bottles and other containers cost 3.22 cents for each dollar of product sold. Operating costs totaled 98.02 cents, leaving an operating profit of 1.98 cents for each dollar of sales.

The study, made for the Milk Industry Foundation, was based on reports direct to the bureau from 244 companies in major cities throughout the country with sales in excess of \$583,000,000 in 1944.

The Indiana University cost study was made following a national poll of consumer opinion by the Opinion Research organization which showed 43 per cent of the consumers think distributors make from 3 cents to 9 cents a quart profit.

The poll of consumer opinion also showed that only three out of every ten consumers know anything about Government subsidies which hold down retail prices.

**Press Clippings.**—Some news items from the daily press on matters related to medical practice follow:

**Extract Found to Kill Tuberculosis Bacilli**

Los Angeles, Sept. 14.—(AP.)—Dr. Anthony J. Salle, assistant professor of bacteriology at the University of California at Los Angeles, says he has discovered that a bacillus extract known as subtilin will kill tuberculosis bacilli.

"Subtilin is much like penicillin," said the bacteriologist, "but it goes further in this particular field. Penicillin is not deadly to the tuberculosis bacillus, but subtilin is. It is also fatal to other bacilli, including streptococcus, staphylococcus, pneumococcus and gonococcus."

Salle, who has been working on the subtilin project for seven months with a co-worker, research assistant Gregory Jann, said the substance is derived from a bacterium called bacillus subtilis, commonly known as "hay bacillus," which is found in the ground, in the air and on hay.

In Chicago, Dr. Maurice Fishbein, editor of the *Journal of the American Medical Association*, made this comment on Dr. Salle's announcement:

"There is little reason to be optimistic about the study at this time.

"Many new drugs have been found in the past to control the organisms of tuberculosis in the test tube, but when they were applied to the human body they did not prove effective. There is no reason why the search should not continue; yet there is little reason to be especially optimistic about this discovery at this time."—*San Francisco Call-Bulletin*, September 14.

**My Day**

Hyde Park, Sept. 6.— . . . Most people who have even moderate incomes prepare for the advent of a baby and lay the money aside. If there are no great complications, that does not cause a complete dislocation of the family budget. It has meant a great deal to many young wives of men in the service to be taken care of under the E.M.I.C. Plan, and I have had a number of them say rather wistfully that they wished such a plan could continue functioning in peacetime. . . .

It seems to me the Government might well guarantee that these two phases of the health of the Nation shall go forward unhampered and properly financed.

The Senate Health Bill, as proposed, puts much responsibility on the states. But it does leave supervision in the hands of the surgeon general, and I think the advisory committee gives the kind of safeguard which should make sure that there will be no hampering of either research or education in the future.

Federal assistance should be available for the handling of hospitals and clinics. This, of course, is essential, since many communities can meet the running expenses, but are unable to make the first capital investment for buildings and equipment.

On the whole, the Wagner-Murray-Dingell health bill seems to me to give us more hope than we have ever had for health in our communities throughout the Nation.—Eleanor Roosevelt in *San Francisco News*, September 7.

**British Find New Chemical a Super DDT**

Boston.—A super-DDT, a synthetic compound even deadlier to insects than the original DDT, has been discovered by British chemists. It is known by the convenience-name of Gammexane, and is sometimes referred to by the Apocalyptic number 666. Its exact chemical designation is the gamma isomer of benzene hexachloride.

Not closely related to DDT in its structural chemistry, the compound seems to be even more of a knockout so far as insects are concerned, a report by A. D. Little, Inc., states. By a curious coincidence, its history is like that of DDT in that its existence had been known for a long time, but its insecticidal properties had not been suspected until it was tried out relatively recently. Then it was discovered to be the deadliest weevil poison that the British firm's chemists had ever tested, and it would kill flies in half the concentration required in a DDT solution. It was also proven to be deadlier than DDT to *Aedes aegypti*, the mosquito that carries yellow fever.

It is not known whether Gammexane is as persistent as DDT under ordinary use.—*Science Service*.

**Housewives Cautioned Against Improper Use of DDT in Home**

*Keep Poisonous Powder Away From Kitchen Supplies, Dr. Fishbein Advises; Says Large Doses Can Prove Harmful*

Housewives who find use for DDT, the powerful new insecticide known to chemists as dichlorodiphenyltrichlore-

thane, are cautioned against placing the poisonous powder where it might be mixed with kitchen supplies.

"In large doses DDT is poisonous to human beings and to a good many animals," writer Editor Morris Fishbein, M.D., in the October issue of *Hygeia*, the health magazine of the American Medical Association. "When DDT is properly used, these poisonous effects are controlled; if it is improperly used, they may be harmful." Continuing, Dr. Fishbein said:

"Experiments made during the war show that DDT has a great variety of uses as an insecticide. It gets rid of mosquitoes, bedbugs, lice, fleas, moths and other insects.

"Since it can destroy fish, cattle or fowl if taken in large amounts into the body, its use should be limited so as to prevent the destruction of animals.

"DDT is best used as a spray, or as a powder, in the concentrations that have been found to be efficient for specific purposes.

"DDT is known to be efficient against the codling moth that attacks apples, the cherry fruit fly, the cabbage worm, the grape-herry moth, and the raspberry fruit worm.

"Against ants and termites DDT is toxic in relatively low concentrations. Ants exposed to a five per cent solution have difficulty in walking within a few minutes after coming in contact with it. After half an hour, most of them are unable to stand up; they die several hours later. Termites avoid DDT if it is in their neighborhood, but a great deal more needs to be known about ways to get termites into contact with DDT. When DDT is sprayed on house screens, dissolved, as it frequently is, in kerosene, it is effective in destroying flies and preventing their entrance into homes. It has been found useful against fleas on dogs and against roaches.

"DDT, when used to destroy insects, is mixed with other substances. Thus the user is confronted with the hazards not only of DDT but also of the substances with which it is mixed. Kerosene is inflammable; this carries a fire hazard. In the weak dilutions in which DDT is usually used—anywhere from one to three or five per cent—around the house as a spray or a powder for dusting, it is relatively safe. When used in immense quantities, the possibility of inhaling large amounts of DDT into the lungs brings another hazard. People who are professionally engaged in the work of insect extermination should probably use respirators for their own protection."

In reviewing DDT's development, Dr. Fishbein explained that the chemical had been known for almost 70 years. When the Germans passed up an opportunity to make use of it, Swiss scientists synthesized the product and found out its insecticidal value. As far back as 1938 it was used to get rid of a beetle which threatened Switzerland's potato crop.—*J.A.M.A.*, Sept. 13.

**Newsprint Controls May Be Ended December 31**

Washington, Sept. 13.—(AP.)—All government controls on newsprint will be abolished December 31, it appeared likely today, and paper allocations to United States publishers will be increased for the fourth quarter.

Relaxation of newsprint usage restrictions one full degree in the sliding scale formula of deductions beginning October 1, and revocation of Limitation Order 240 at the end of the year were recommended by the newspaper industry advisory committee at a two-day session with War Production Board officials, the agency announced. . . .—*Los Angeles Times*, September 14.

**LETTERS †**

**Concerning California Board of Medical Examiners—Examination and Reciprocity Statistics:**

September 21, 1945.

Frederick N. Scatena, M.D., Secretary  
California State Board of Medical Examiners  
1020 N Street, Room 536  
Sacramento 14, California.

Dear Doctor Scatena:

In CALIFORNIA AND WESTERN MEDICINE for June, 1945, on P. 315, was printed the address you gave at this

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.



year's annual session of the California Medical Association.

In that report you gave statistics concerning the number of those who had taken written examinations and reciprocity-oral examinations. The figures were not given for the year 1945.

\* \* \*

I am writing to ask if you have statistics for the first six months of the current year.

Inquiries have come in asking for information concerning the number of physicians who have not had licenses in California, and who are applying for such either through written examinations or through reciprocity-oral examinations.

What information can you give us in regard thereto?

\* \* \*

Under the present interpretation of the Medical Practice Act for M.D. physicians and surgeons, how often is the State Board of Medical Examiners holding examinations?

Cordially yours,

GEORGE H. KRESS, M.D., *Editor*.

' ' '

(COPY)

STATE OF CALIFORNIA

Department of

PROFESSIONAL AND VOCATIONAL STANDARDS

Board of Medical Examiners

Sacramento, California, September 26, 1945.

Yours of September 21st. Re: Statistics.

Dear Doctor Kress:

In view of the law which states that an examination must be afforded an applicant within six months of the filing date, the numbers of examinees so falling due will determine the number of oral examinations we will have each year.

Written examinations are usually conducted four times a year. A written examination is held at each regular meeting of the Board of which there are three, and a special written examination was held this year in San Francisco to accommodate those who, because of the accelerated medical course, were graduating at a time falling between our regular examinations. We enclose herewith a memo giving the number of applications for written examination and the number of applications for reciprocity filed between January 1 and July 1, 1945.

Our statistics are as follows:

Class A: Written.....	342
Class C: Reciprocity.....	382
Class D: Government Credentials.....	16
Class G: National Board.....	47

787

Very truly yours,

(Signed) FREDERICK N. SCATENA, M.D.,  
*Secretary-Treasurer*.

#### Concerning Relative Amount of Energy in Climbing and Walking:

STANFORD UNIVERSITY

Department of Physiology

Stanford University, California, Sept. 17, 1945.

Dear Mr. Kress:

In reply to your letter of Aug. 13 requesting information for Mr. Jerry Carpenter, State Chamber of Commerce regarding "the relative amount of energy required

by men and women in climbing stairs, as against traveling on level ground."

The most accurate work along this line that I have found is "Gaseous Exchange and Physiological Requirements for Level and Grade Walking," by H. M. Smith, Publication No. 309, Carnegie Institution of Washington, 1922. In this paper it is shown that the increase in energy expenditure in walking horizontally amounts to about 0.5 gram calories per kilogrammeter. Walking up a grade requires an expenditure of 7.5 gram calories per kilogrammeter. Stairs are usually built so that the tread (horizontal distance) and the riser (vertical distance) are definitely related, e.g., 2 risers plus one tread = 23". On the stairs in my house the riser = 16.5 cm. and the tread = 28.5 cm. A 50 kilo man climbing 10 such steps would expend energy as follows:

Horizontal progression,  $50 \times 10.0 \times 0.285 \times 0.5 = 71.25$  gm. cal.  
Vertical progression,  $50 \times 10.0 \times 0.165 \times 7.5 = 608.75$  gm. cal.

Therefore it requires nine times as much energy to climb the stairs as it would to progress the same horizontal distance.

I hope this information is adequate but will be glad to go into the subject at greater length if need be.

Yours sincerely,

J. PERCY BAUMBERGER,  
(*Prof. Physiol.*)

#### Concerning Generous Gift to Barlow Sanatorium by Los Angeles Elks:

THE BARLOW SANATORIUM ASSOCIATION

Incorporated under the Eleemosynary Laws of California

1301 Chavez Ravine Road

Founded by Dr. W. Jarvis Barlow

Los Angeles, California, October 2, 1945.

CALIFORNIA AND WESTERN MEDICINE

450 Sutter—Room 2004

San Francisco, California.

Sirs:

This is to announce that the Barlow Sanatorium of Los Angeles has just received a gift of \$12,000 from the B.P.O. Elks Lodge No. 99 of Los Angeles for the establishment of a library for research in tuberculosis.\* This fund is intended to finance the erection of a small building, the purchase of furniture and equipment, books and medical journal subscriptions. It is hoped to build up as complete a library as possible in the field of tuberculosis and diseases of the chest.

This library will be designed to serve the staff of the Sanatorium, the teaching of student nurses in tuberculosis, teaching of medical students from the University of Southern California in tuberculosis, post graduate courses for physicians in tuberculosis, an physicians or other persons in this area seriously interested in tuberculosis. The reading room of the library will be designed for use as a class room for staff meetings, committee meetings, lectures, etc.

It will be known as the Elks' Tuberculosis Library of the Barlow Sanatorium.

Sincerely,

The Barlow Sanatorium Association,  
HOWARD W. BOSWORTH, M.D.,  
*Medical Director*.

\* Coöperation of B.P.O. Elks Lodge No. 99 of Los Angeles made it possible for California Medical Association to obtain meeting room facilities for the annual session held this year on May 6-7, 1945.

The late W. Jarvis Barlow, M.D., founder of the Barlow Sanatorium also founded the Barlow Medical Library, later to become the Library of the Los Angeles County Medical Association.—Ed.

## TWENTY-FIVE YEARS AGO†

### EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 10, October, 1920

#### EXCERPTS FROM EDITORIAL NOTES

*Attention, Physicians, Voters!*—Are you interested in continuing the practice of scientific medicine in California? Do you believe scientific medicine has any contribution to make to California in her social, economic and health development? Do you recognize that being a physician ought to make you a better citizen? Do you know that the election on November 2, 1920, so far as it affects these points, will be determined by what YOU do? . . .

#### EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

*From an Article on "The Present Status of Anesthesiology and the Anesthetist," by Eleanor Seymour, M.D., Los Angeles.*—The administration of anesthetics is an art ancient and honorable, signalized as are few procedures by both divine sanction and usage, for in the second chapter of Genesis it is recorded that "the Lord caused a deep sleep to fall upon Adam and he slept, and He took one of his ribs and closed up the flesh instead thereof." It is cause for regret that there is no detailed account of the induction and maintenance of this first anesthetic but it is evident that the administration was considered of such importance as not to be entrusted even to the Angel Gabriel,—must less an angelic nurse,—and of Adam's safe and satisfactory recovery there is abundant record. . .

*From an Article on "Some Recollections and Ophthalmologic Observations from Service in the A.E.F. in France," by Vard H. Hulén, M.D., Berkeley, California.*—As only a few members of this section had service in the A.E.F., some observations based on my experiences "over there" may be of more interest to you than a scientific effort limited to fifteen minutes, and a discussion of my deductions may be of some practical use even now.

The goal of every medical man who early volunteered his services was naturally France, so that when directed in September, 1918, to join B. H. 104, then almost completely organized at Camp Dodge, Iowa, destined for overseas service, I was relieved from the suspense of having waited nearly six months for overseas orders. . .

*From an Article on "Californians on the Italian Front—Historical," by Thomas C. Myers, Major M. R. C., Los Angeles.*—Through the generous gift of \$100,000 by Mrs. Diebert of New Orleans a hospital unit was organized in the United States known as the Loyola Unit, afterwards accepted by the U. S. A. as Base Hospital No. 102. The selection and organization of the nursing corps were delegated to the Sisters of Charity who were peculiarly fitted for this duty by reason of their management of many hospitals and training schools throughout the United States. . .

*From an Article on "End Results of Radical and Conservative Pelvic Surgery," by Alice F. Maxwell, M.D.,*

(Continued in Back Advertising Section, on Page 30)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco 8.

## BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M.D.  
Secretary-Treasurer

#### Board Proceedings

A regular meeting of the Board of Medical Examiners will be held at 1020 N St., Sacramento, from October 15 to 18th, 1945. Written examinations for all classes will be conducted and legal hearings will be conducted during the meeting.

#### News

"Found guilty of three counts of practicing medicine without a license, Mrs. Pauline Vigil of 1823 N. Buena Vista St., today had filed notice of an appeal. The jury reached a verdict of guilty in a case tried before Police Judge Raymond L. Reid's court. Charges had been preferred by the State Board of Medical Examiners, under the Business and Professions Code." (*Hollywood Citizen-News*, August 14, 1945.)

"A Glendale physician was under arrest today charged with falsifying a birth certificate to enable the adoption of a 'black market baby' without the formality of going through state controlled adoption, according to Glendale police. He was Dr. Philip V. Abrams, 30, of 1601 Griffith Park boulevard, Glendale, who maintains an office in that city at 115 West Hayworth Avenue. . . ." (*Los Angeles Herald and Express*, August 9, 1945.) The records show that Dr. Abrams is under jurisdiction of the Board of Osteopathic Examiners.

"In Long Beach, California, a woman 'doctor' has been indicted for murder and police believe that through her arrest they have cleaned up 'one of the nation's largest abortion mills.' The woman has admitted that she performed from 30 to 35 abortions each week for the past two years—a total of more than 3,000. Her arrest followed the death of one of her 'patients,' the wife of a navy man. The woman spoke freely to police of her life-destroying work, and said that she had been engaged in the nefarious practice of performing abortions ever since she moved to California 18 years ago. . . ." (*Banning Live Wire*, July 12, 1945.)

"Dr. Samuel D. Collins, 42, chiropractor, accused of performing illegal operations which led to one death and another critical illness, today was free on \$7,500 bail and denied performing either operation. Trial has been set for Sept. 28. Collins was seized in front of Georgia Street Receiving Hospital after police reported he tried to push Crystal L. Hawkins, 23, from his automobile. At the hospital, Mrs. Hawkins was found to be suffering from the effects of an illegal operation. The chiropractor is also under suspicion in connection with the death of Margie F. Wilson, 20, also from an illegal operation, July 27." (*Pasadena Star-News*, August 7, 1945.)

"His 'love cure' prescription and subsequent beating of the woman patient who refused it today sent Dr. Wendell White, 35-year-old Glendale physician, to jail for 90 days of a 180-day term. Police Judge Charles Dwyer sus-

(Continued in Back Advertising Section, on Page 32)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the secretary of the board.





# Smoothage

## IN COLITIS MANAGEMENT...

METAMUCIL

*Metamucil is  
the registered  
trademark of  
G. D. Searle & Co.,  
Chicago 80, Illinois*



The demulcent smoothage effect of Metamucil makes it a valuable adjunct in the various forms of colitis—spastic, atonic and ulcerative.

The tendency of Metamucil to incorporate irritating particles within the intestinal residue assists materially in minimizing irritation of the inflamed mucosa.

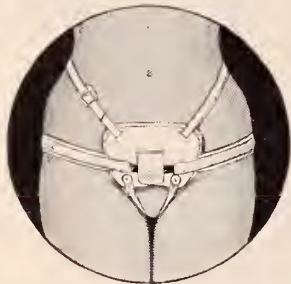
*Smoothage* describes the gentle, non-irritating action of Metamucil—the highly refined mucilloid of a seed of the psyllium group, *Plantago ovata* (50%), combined with dextrose (50%).

# SEARLE

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Accident, Hospital, Sickness



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\$5,000.00 accidental death	For \$32.00 per year
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\$15,000.00 accidental death	For \$96.00 per year
\$75.00 weekly indemnity, accident and sickness	

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43 years under the same management

**\$2,700,000.00 INVESTED ASSETS**  
**\$12,700,000.00 PAID FOR CLAIMS**

\$200,000.00 deposited with State of Nebraska for protection of our members.

Disability need not be incurred in line of duty—benefits from the beginning day of disability.

86c out of each \$1.00 gross income used for members' benefit

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**PHYSICIANS HEALTH ASSOCIATION**

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KEVIN McGETTIGAN  
Manager

**PARK SANITARIUM 1500 PAGE ST.**  
SAN FRANCISCO.

### TWENTY-FIVE YEARS AGO

(Continued from Text Page 204)

San Francisco, Instructor in Obstetrics and Gynecology, University of California Medical School.—For many years, gynecologists have been keenly interested in two problems, namely, the proper treatment of chronic pelvic inflammatory disease in women during the child bearing age, and the conservation or removal of ovaries with hysterectomy.

The material for this study has been furnished by the records of the Woman's Clinic of the University of California Hospital and consists of 446 cases. In order to obtain a clear and accurate impression as to the postoperative results and sequelae in any compilation, it is very essential that a report be obtained of consecutive cases of the series. . . .

From an Article on "The Significance of the Science

of Obstetrics and Gynecology Considered as Specialties," by Henry P. Newman, M.D., San Diego, California.—What keeps medicine in an unassailable place, is not knife, needle or suture, nor the skill of the hands that wield them; it is the indomitable purpose to help and save humanity from its own errors, at whatever price. It is just the lack of this vital principle that distinguishes practitioners of the free and unlimited profession of medicine from those of other so-called "schools," whose claim to existence is founded on allegiance to manner and method. If this were better understood there would be less confusion concerning the merits of this and that system.

Gentlemen, we are not here because we are artists or artisans of methods and procedures, but because of our lifelong preoccupation with disease, and our determination to conquer, by mutual study and communication, ever

(Continued on Page 32)



A COMMON

# "POINT OF ATTACK"



*Perhaps the most common  
manifestation of cosmetic  
allergy is lipstick cheilitis.*

**F**OR PATIENTS allergic to ordinary lipstick —  
ALMAY provides one of the finest lipsticks  
which can be made — free from common sen-  
sitizer...and available with or without indeli-  
ble dye, scented or unscented, and in eight  
popular shades. • ALMAY also offers a *complete*  
*line* of hypoallergenic cosmetics — including  
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many other beauty aids for sensitive skins.  
• For physicians confronted with the greater  
problem of *hyperallergic* patients, ALMAY  
supplies Raw Material and Clinical Testing  
Sets to assist in diagnosis — and cooperates  
with the physician in developing personal-  
ized cosmetics for the stubbornly allergic.

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*Write for free copies of  
"Cosmetic Sensitivity" and  
"Cosmetic Formulary"*



SOLE DISTRIBUTORS: Schieffelin & Co. NEW YORK 3, N. Y.



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"THE NAME TELLS THE STORY"

### HYPO-ALLERGENIC

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Available at prescription pharmacies throughout California, as follows:

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 Los Angeles: All Horton & Converse Prescription Pharmacies  
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 Modesto: Thorne's Prescription Pharmacy

Oakland: Peralta Hospital Pharmacy  
 Pasadena: Erikson & Quinn  
 Horton & Converse Prescription Pharmacy  
 Exclusive Prescription Pharmacy  
 Sacramento: Pucci's Professional Pharmacy  
 Salinas: Holaday's Pharmacy  
 San Francisco: Lane Prescription Pharmacy, 809 Flood Bldg.  
 H. L. Ladd Pharmacy (St. Francis Hotel)  
 San Jose: Columbia Pharmacy  
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## Physicians Formula Cosmetics, Inc.

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Fully equipped for the diagnosis and modern treatment of diseases of the chest, including tuberculosis and other respiratory diseases

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 Resident Clinicians

### TWENTY-FIVE YEARS AGO

(Continued from Page 30)

advancing and widening fields of endeavor. The preparation for the right to practice such a profession as ours is being made harder and more exacting every year, and this by our own election. With every year that multiplies practitioners of the easier, "get-rich-quick" schools, we demand from ourselves a stricter accountability to the law, a greater responsibility toward our patients and a higher standard of ideals in answering to our conscience. It is not for our livelihood that we follow this science, but for higher values in human life. . . .

Men resemble their contemporaries even more than their progenitors.

—Emerson, *Representative Men: Uses of Great Men.*

All, as they say, that glitters is not gold.

—Dryden, *The Hind and the Panther*. Pt. ii, 1.215. (1687)

### BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 204)

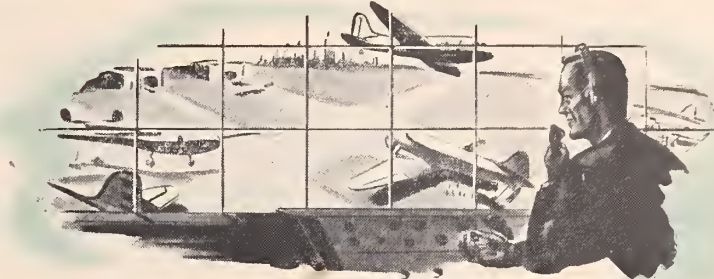
pendent another 90 days of sentence and placed White on one year's probation on his plea of guilty to battery charges. The physician was accused of offering to administer 'love treatments' for \$10 apiece to Mrs. Sidnie Leonard after he examined her in his office. When she refused, Mrs. Leonard said White kicked her and hit her in the stomach. 'This is not the only case against you reported to the police. Ever since your arrest we have reports that you beat other women,' Judge Dwyer told White." (Burbank Review, August 17, 1945.)

"Pleas of innocence were entered in superior court yesterday by Dr. Lloyd Tilbury, Oceanside osteopath, and Mrs. Georgia R. Renfrow, nurse assistant, charged in a

(Continued on Page 36)



## POWERFUL TO DECONGEST



*Powerless to Re-congest...* In the symptomatic treatment of common colds and sinusitis, Neo-Synephrine is noteworthy for its long-lasting decongestive action which promotes breathing comfort and facilitates sinus drainage. Noteworthy also is its marked freedom from compensatory re-congestion and systemic side effects.

# Neo-Synephrine

## HYDROCHLORIDE

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### FOR NASAL DECONGESTION



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**THERAPEUTIC APPRAISAL:** Quick-acting, long-lasting...nasal decongestion without compensatory re-congestion or significant stimulation of the heart and central nervous system; consistently effective upon repeated use; no appreciable interference with

ciliary activity, isotonic to avoid irritation.

**INDICATED** for symptomatic relief in common cold, sinusitis, and nasal manifestations of allergy.

**SUPPLIED** in 1/4% and 1% solutions, bottles of 1 fl. oz.; 1/2% jelly in col-

lapsible tube with applicator.

**ADMINISTRATION** may be by dropper, spray, or tampon, using the 1/4% solution in most cases and the 1% when a stronger solution is indicated. The 1/2% jelly in tubes is convenient for patients to carry.

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# Colfax School for the Tuberculous

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There are two units, The Colfax Hospital and the Bushnell Sanatorium, for the treatment of Pulmonary Tuberculosis.

The Colfax School for the Tuberculous is located in the pine clad Sierra Nevada foothills, at an elevation of 2,400 feet; an elevation free from the fogs of the valleys and free from extremes of heat or cold.

This Institution supplies, among other advantages:

1. Individual care and supervision under skilled physicians.
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5. An absence of institutional atmosphere.
6. Reasonable rates.

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**ROBERT A. PEERS, M.D.**

Medical Director  
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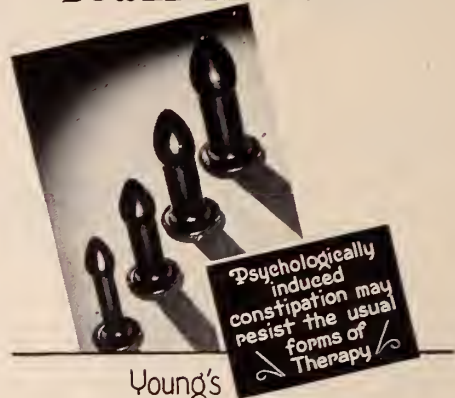
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"BOWEL LAZINESS"



## Young's RECTAL DILATORS

Bowel laziness is often the result of unconscious fear—a sort of rectal inferiority induced by prudish notions or irregular bowel habit. In these cases the rectal muscle is in a state of constant tension and may be compared to a clenched fist. Undue tightness of the anal sphincter is a frequent cause of chronic constipation.

This form of bowel laziness can only be overcome by breaking the impulse by the rectal exit muscle to keep itself locked and Young's Bakelite Rectal Dilators have been found very effective in restoring sphincter tone. There are four dilators graduated in size and introduced in series through the anal canal and into the rectum. Their use obviates harsh cathartics and consequent dehydration of the patient.

*Sold on Physician Prescription Only*  
Not advertised to the laity. Set of four as shown, \$3.75. Children's size, set of four, \$4.50. Available for your patients at ethical drug stores or order from your surgical supply house.

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## ERYTHROL TETRANITRATE MERCK in Angina Pectoris

It is generally agreed that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of nitrites. For this purpose, the rapidly acting nitrous and nitric acid esters, amyl nitrite and nitroglycerin, are considered most useful.

For prophylactic purposes—to control anticipated paroxysms—the *delayed but prolonged action* of erythrol tetranitrate is more effective. Erythrol tetranitrate, because of its *slower and more prolonged action*, is also considered preferable for the purpose of preventing nocturnal attacks.

The vasodilatation produced by Erythrol Tetranitrate Merck begins 15 to 20 minutes after administration, and lasts from 3 to 4 hours.

*The properly timed administration of a vasodilator having a sustained effect may prevent the following episodes of angina pectoris:*

- The man who finds it necessary to stop and rest when he walks to the train in the morning.
- The man who suffers "indigestion" and "gas" on exertion, or after a heavy meal.
- The man who has pain in his chest and arms, and weakness upon any anxiety, anger, or nervous strain.



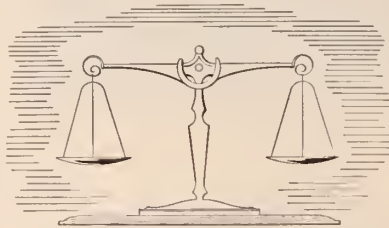
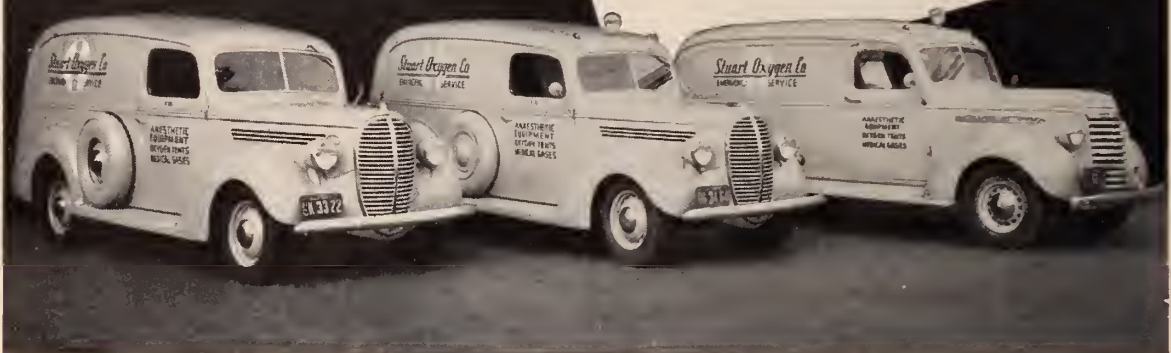
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*Balance* . . . a nice word—a desirable condition. When two eminent physiologists, Dr. James J. Hogan and Dr. Martin H. Fischer, developed the Calso formula thirty-two years ago, they made an important contribution, which has ever since enjoyed widespread and generous recognition by American medical men.

*Indications* for all genito-urinary infection, particularly the irritated bladder of prostatics. Pre- and post-operative treatment. Fluid depletion Pregnancy. Indicated in combinations with Sulfa therapy.



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## PENICILLIN SCHENLEY

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The penicillin which first attracted the attention of Alexander Fleming was an "occurrence of nature", with no control exercised over the conditions of its production. Production of pyrogen-free penicillin for the medical profession, however, is accomplished only by the most elaborate methods of control for insuring highest attainable productivity, potency, and purity.

Shown here is one of the many rigid controls exercised at the Schenley Laboratories. In this step, PENICILLIN SCHENLEY is being tested to insure standard potency. Such measures of elaborate control are your assurance that you may specify PENICILLIN SCHENLEY with the greatest confidence.



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*Use* **LIVCAL** *for* **General Debility, Asthenia  
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An Ideal Intramuscular Tonic  
Containing Liver - Iron - B Complex

30 cc. Vials

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Individual care, modern treatment, and pleasant atmosphere . . . for  
nervous cases and borderline mental illness.

Allen H. Williams, M.D.

Medical Directors

Albert T. Voris, M.D.

### BOARD OF MEDICAL EXAMINERS

(Continued from Page 32)

grand jury indictment with abortion. Their trial was set for Sept. 17 and they remained at liberty under \$2,500 bail each. The doctor and his assistant are charged with having performed an illegal operation on the wife of a serviceman now overseas." (San Diego Union, August 15, 1945.)

"Establishment of a psychiatric clinic in Los Angeles County was one step nearer today with the announcement that Governor Warren had signed a bill appropriating \$100,000 to buy a site for the institution." (Pasadena Star-News, July 19, 1945.)

### X-Ray—Its Discovery and Application in Medicine *Fiftieth Anniversary of the Discovery of X-Ray (Roentgen)*

*Discovery:* The x-rays were discovered on November 8, 1895, by Wilhelm Conrad Roentgen, a German physicist, at the Physical Institute of the University of Wurzburg in Bavaria. Like many scientific discoveries, x-rays were first detected by accident, Roentgen noting them while concerned with other experiments.

Although he was baffled by the nature of his discovery

—thus terming it x-rays for unknown quantity—Roentgen realized almost immediately that he had something that would be a boon to mankind, especially after he learned the rays would penetrate the human body and reveal the bone structures. One of his first "pictures" was of the bone formation in his own hand.

In an interview soon after he announced his discovery, Roentgen was asked:

"Now professor, will you tell me the history of the discovery?"

"There is no history," Roentgen replied: "I have been for a long time interested in the problem of the cathode rays from a vacuum tube, as studied by Hertz and Lenard. I had followed theirs, and other researches, with great interest, and determined, as soon as I had time, to make some researches of my own. I had been a work for some days when I discovered something new."

"What was the date?"

"The eighth of November."

"And what was the discovery?"

"I was working with a Crookes tube covered by a shield of black cardboard. A piece of barium platino-cyanide paper lay on the bench there. I had been passing the current through the tube, and I noticed a peculiar black line across the paper."

(Continued on Page 39)



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San Francisco

## X-RAY—ITS DISCOVERY AND APPLICATION IN MEDICINE

(Continued from Page 38)

"What of it?"

"The effect was one which could only be produced, in ordinary parlance, by the passing of light. No light could come from the tube, because the shield which covered it was impervious to any light known, even that of the electric arc."

"And what did you think?"

"I didn't think; I investigated. I assumed that the effect must have come from the tube, since its character indicated that it could come from nowhere else. I tested it. In a few minutes there was no doubt about it. Rays were coming from the tube which had a luminous effect on the paper. I tried it at greater and greater distances, even at two meters. It seemed at first a new kind of invisible light. It was clearly something new; something unrecorded."

"Is it light?"

"No."

"Is it electricity?"

"Not in any known form."

"What is it?"

"I don't know."

Two months after his actual discovery, Roentgen reported his finding in a paper, "A New Kind of Ray," read before the Physical Medical Society of Wurzburg. The news in his report spread like wildfire, electrifying the world.

1 1 1

*Early Reaction.*—The medical profession recognized the vast significance of Roentgen's discovery almost immediately. "Here," doctors said, "is a device which allows us to turn our patients inside out." X-rays were used first in medicine to detect bone pathology, but within a short time, x-ray films also recorded pathological conditions of the heart and the lungs, since these organs also

(Continued on Page 40)

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Gerald L. Crenshaw, M.D., Oakland  
Ina Gourley, M.D., Oakland

## X-RAY—ITS DISCOVERY AND APPLICATION IN MEDICINE

(Continued from Page 37)

showed up clearly on the film. Almost overnight, much guesswork was eliminated from medical practice.

Newspapers all over the world published stories, cartoons and even poems about the new "wonder rays." They printed skeletons of hands and feet of living persons and extolled the mysterious powers of the new rays, which could "see" through almost anything. As a result, a member of the New Jersey assembly introduced a bill which forbade the use of x-rays in opera glasses in theaters. A London firm "made prey of ignorant women by advertising the sale of x-ray-proof clothing." An eastern newspaper went so far as to speculate that the

new rays might solve the problems of spiritualism and soul photography. Another paper said a well known medical school was using x-rays to reflect anatomic diagrams directly into the brains of students, thereby making a more enduring impression than the ordinary methods of learning.

*The Profession of Radiology.*—In the early days of x-ray, an exposure of thirty minutes was sometimes necessary to get a readable film. Today, due to developments in equipment, an exposure can be made in less than a second.

Soon after physicians began to use x-ray, the equipment was usually operated by a photographer or a fellow with engineering experience. Today, the x-ray specialist is a trained physician—a radiologist—who, having devoted several years to the study of radiology after his

(Continued on Page 42)





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## X-RAY—ITS DISCOVERY AND APPLICATION IN MEDICINE

(Continued from Page 40)

graduation from medical school, passes an examination to qualify as a member of this specialized branch of the medical profession.

Radiology became a medical specialty when it became apparent that the effective use of x-ray in medicine depended upon a proper interpretation of x-ray findings. This interpretation could only be made by one with a firm foundation in the medical sciences and a special knowledge of physics, as the latter apply to x-ray. For example, anyone can detect a broken bone on an x-ray film. However, it takes one with a thorough knowledge of anatomy, physiology and pathology to determine if the broken bone resulted from injury or disease.

The field of radiology has advanced so far within recent years, that sub-specialization is going on within

this branch of the profession. At the present time, there are radiologists who devote their entire time to therapeutic radiology, that is, the treatment of disease; while others confine their efforts to diagnosis, entirely.

The present-day radiologist has his own office or he is the director of the radiology department at a hospital. Usually, the radiologist works in coöperation with the patient's physician, lending his specialized skill to diagnosis, and/or treating the patient, if x-ray therapy is indicated.

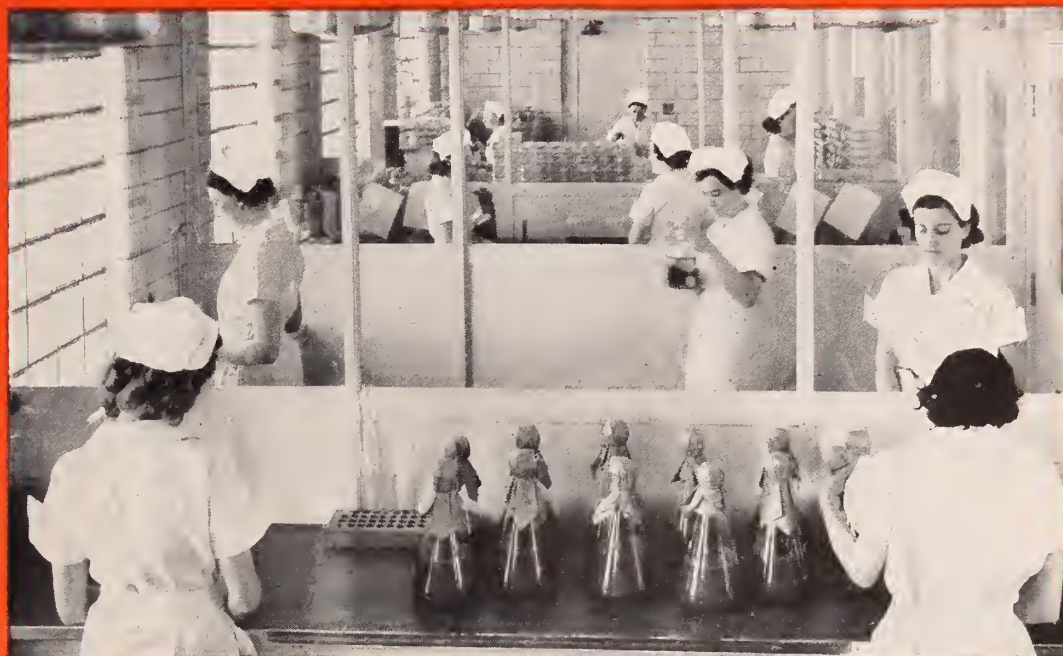
*What Are X-Rays.*—Nearly a half-century before American fliers blasted Japan out of the war with atom bombs, Roentgen turned on the current in his Crookes tube and sent millions of electrons crashing into the atomic structure of the tube's metal anode.

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(Continued on Page 44)



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### X-RAY—ITS DISCOVERY AND APPLICATION IN MEDICINE

(Continued from Page 42)

at the same time releasing the mysterious radiations so powerful they penetrated the black cardboard shield covering the tube and registered on a piece of sensitized paper.

The high frequency radiations which are released when electrons strike a metal object with sufficient impact are the x-rays which vary in quantity and quality, depending upon the amount of voltage applied to the tube.

The electron, a negatively charged particle, is one of the smallest of the fundamental building blocks of matter. Put 30,000 trillion billion (that's 30 with 27 zeros after it) electrons together and they would weigh less than an ounce.

Activate the electron, however, with high voltage elec-

tric current and you have a projectile which travels at a rate of speed terrific enough to carry the tiny particle into the atomic structure of metal.

Under a voltage of 50,000 volts, the electron attains a speed of 77,200 miles per second; step up the voltage to 400,000 and the electron speed will approximate 155,000 miles per second.

The modern x-ray unit varies in power from the small tubes used by dentists to examine a patient's teeth to huge units with more than 1,000,000 volts of power for therapeutic and industrial purposes.

The rays, in many respects, are similar to visible light with the basic difference that the wave lengths of x-ray are shorter than the waves of ordinary light.

Because of the shorter wave length, x-rays are able to penetrate solids which resist visible light.

(Continued on Page 50)





## This, too, will be written in history



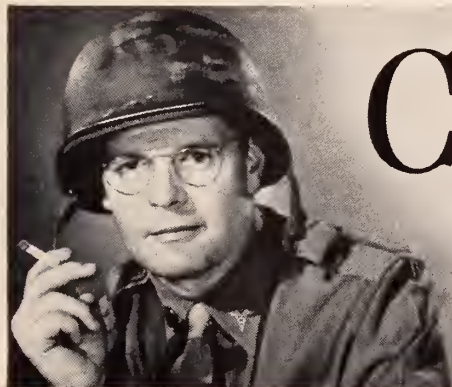
Among the many brilliant originations, the inspired improvisations, of the Medical Corps in World War II was the use of the "ambulance on wings."

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tion, and all the companion advancements of wartime medical science, 97 out of every 100 such casualties *lived!*

Thanks should be proffered most generously to the incredible diligence of those "soldiers in white" who created and tirelessly practiced these techniques—the medical men in the service whose rest all too often was no more than a moment and a cigarette. Incidentally, that cigarette was very likely a Camel, an especial favorite of all fighting men.

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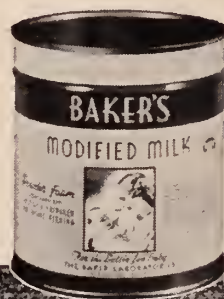
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Baker's Modified Milk is advertised exclusively to the medical profession, with feeding instructions supplied to physicians and hospitals only. Write for full information and samples.

• Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B<sub>1</sub> and D. Not less than 400 units of vitamin D per quart.



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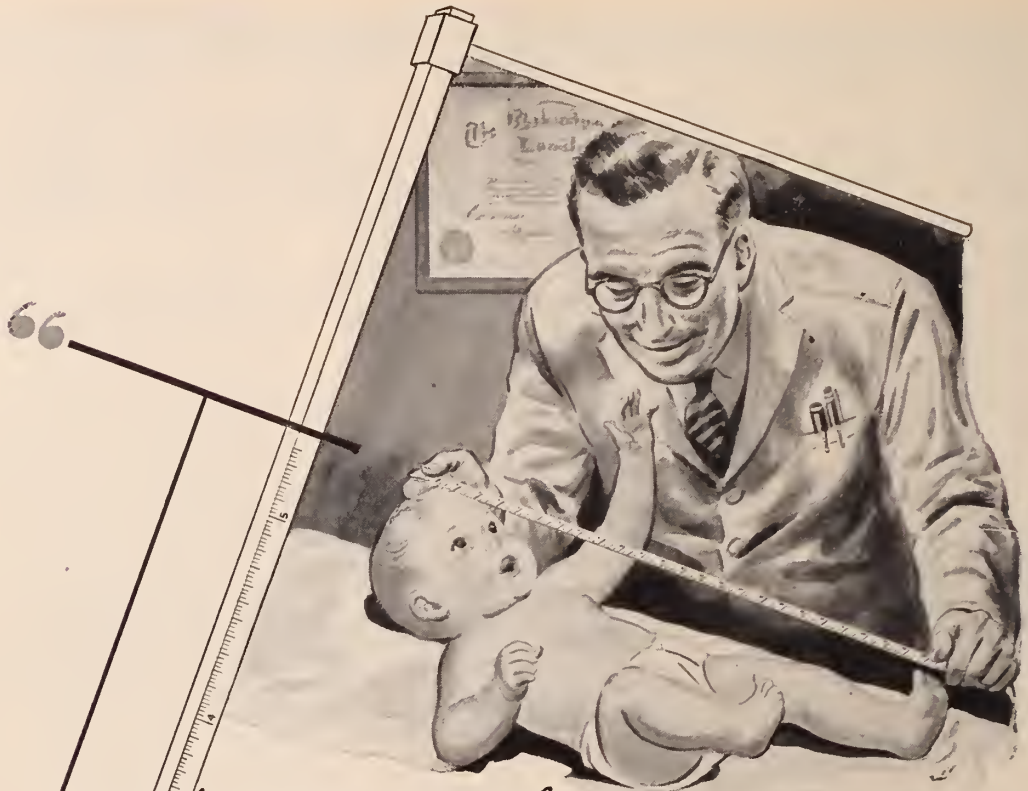
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**X-RAY — ITS DISCOVERY AND APPLICATION IN MEDICINE**

(Continued from Page 44)

*X-Rays in Medicine*

*Diagnosis:* No modern hospital today is without its x-ray department and every physician, surgeon and dentist depends upon the opinion of the radiologist, a physician especially trained in the use of the x-ray, for diagnosis and prognosis in a large portion of his cases.

Practically no region of the body is hidden from the searching eye of x-ray. With its aid, the radiologist can examine the skull, spine and other bones of the body; he can see that a broken bone is set properly and how it is knitting; the x-ray examination will reveal gallstones, kidney stones and bladder stones. Upsets in the physiology of the body often can be detected by the radiologist by

telltale shadows in the intestines, lungs, heart and other organs.

Because tuberculosis of the lungs shows characteristic markings on x-ray film, the presence of the disease can be accurately detected even when other symptoms are lacking. Ulcers and tumors that otherwise would not be discovered until too late for treatment are revealed by x-ray examination.

In x-ray diagnosis, two different methods of examination are used:

1. Radiography, whereby a permanent record of the x-ray image of the part of the body under examination is made on film.

2. Fluoroscopy, which enables the radiologist to study internal organs in motion on a viewing screen.

A radiograph of any part of the body is similar to a photograph except that it is fundamentally a shadow-graph rather than a picture produced by reflected light.

(Continued on Page 52)





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This velvet-smoothness lessens the possibility of irritation during use.

The "RAMSES" Flexible Cushioned Diaphragm is manufactured in sizes of 50 to 95 millimeters in gradations of 5 millimeters. It is available on the order or prescription of the physician through any recognized pharmacy.



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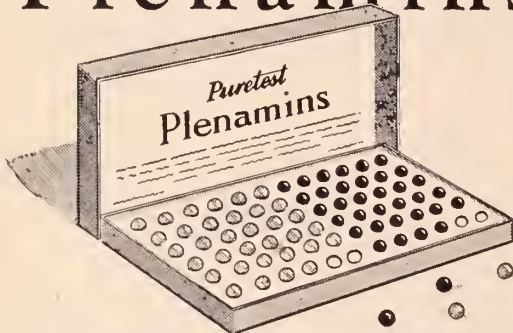
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1 Milligram

**WITH LIVER & IRON**

*The Owl Drug Co*

**131 STORES ON PACIFIC COAST**

## X-RAY—ITS DISCOVERY AND APPLICATION IN MEDICINE

(Continued from Page 50)

The "lights and darks" of the x-ray film depend upon the differences in the density of the tissues situated in the path of the rays before they reach the film. The greater the density or thickness of the object radiographed, the whiter will be that particular area on the film. The radiologist makes his diagnosis on the basis of the shadow images recorded on the film.

The fluoroscopic method of examination involves the use of a cardboard screen coated with chemicals which fluoresce—or give off light—when exposed to x-rays.

When the rays strike the screen after passing through a patient's body, the images of the various organs are seen as dark shadows against an illuminated background.

Because of their lack of sufficient density, such internal organs as the stomach and intestines are not ordinarily clearly visible on the fluoroscopic screen or x-ray film.

For this reason, the organs are filled with a substance comparatively opaque to x-ray to make them stand out clearly. For example, a person who has an x-ray examination of his stomach will be given a milk-like substance to drink. Because the liquid contains barium sulphate, which resists x-rays, the stomach and intestines will be clearly outlined on the x-ray film or fluoroscopic screen.

*Therapy.*—Therapeutically, x-rays have been found useful in treating approximately 80 skin disorders, as well as acute infections, inflammations, gas gangrene and both malignant and benign tumors.

Living tissues undergo certain changes when exposed to x-rays because the tissues of the body absorb part of the rays.



The changes in the physiologic and biologic sections of the tissue vary according to various factors, the chief of which are the quality and quantity of the rays, rate of administration, intervals between treatments, size of exposed field and possible previous exposures to x-rays.

Although a comparative infant in the field of medical science, x-ray already has achieved an imposing record as a therapeutic aid in the war on disease, particularly against cancer.

*X-Ray in World War II.*—During the first World War, an x-ray chest examination was not a routine procedure for men drafted into the armed forces. As a result, the government later had to pay out more than a billion dollars in claims and hospitalization on tuberculosis cases among men in service.

After the passage of the Selective Service Act in 1940, photo-roentgen units—a highly specialized method of x-ray examination particularly suitable for the detection of tuberculosis—were set up in every induction station.

The photo-roentgen equipment makes use of the customary type of x-ray apparatus to throw the image of the chest on a standard-sized fluorescent screen. A small camera is then used to photograph the image on the screen on supersensitive 4 x 5 inch cut film or 70 mm roll film.

Because a 14 x 17 inch film is used in the conventional method of x-ray examination, material costs were cut to about one-tenth of what they would have been.

During the first four years of selective service, about 12 million x-ray examinations were made at induction stations resulting in 120,000 deferments for chest conditions. Thousands of the rejected draftees were not even aware that they had a tubercular condition.

An x-ray survey of 700,000 war workers by the U. S. Public Health Service revealed that 13 of every 1,000 persons had evidence of tubercular infection. The National Tuberculosis Association estimates that each year there are at least 200,000 unsuspected cases of the disease. The Association relies upon x-ray examination as one of the most potent weapons against the disease because through it physicians are able to detect the infection in its early stages when it is easier to effect cures.

In every theater of war and at all military hospitals, the radiologist has played an important part in the treatment and care of battle casualties and the sick.

It is impossible to estimate the enormous contribution x-ray has made to the war, but the records show that about 700 radiologists are now in uniform. Several hundred other medical officers have received special training from the Army or Navy in the science of radiology and they, too, have carried on x-ray's task of aiding in the mending of the wounded and the healing of the sick.

*Future of X-Ray.*—The future of radiological practice will be determined by developments which result from the clinical extension of the applications of x-ray and refinements in the art of roentgen diagnosis.

Through improvements in x-ray apparatus, the clinical use of the rays will be extended and improved. What new uses will be discovered for x-ray are a secret of the future, but radiologists believe the full utility of the rays is yet to be reached.

Regardless of its rôle in the future, however, x-ray already has been responsible for much of the progress made in medicine in recent decades. To the science of radiology must go much of the credit for the advancement made in the treatment of diseases of the lungs, cancer, bone diseases, heart disease, gastric diseases and many infections.



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\*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, *Am. J. Dis. Child.* 66:1-11, July 1943.

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<b>Butte-Glenn County Medical Society</b> President, John H. Alexander, 2nd at Main Street, Chico. Secretary, J. O. Chiappella, 131 Broadway, Chico. Meeting, <i>Second Thursday.</i>	<b>Monterey County Medical Society</b> President, Edwin Wiley Reeves, 605 Salinas National Bank Building, Salinas. Secretary, Dixie M. Bingham, Bank of America Building, Salinas. Meeting, <i>First Thursday.</i>	<b>Santa Barbara County Medical Society</b> President, George R. Luton, 103 E. Michel-torena Street, Santa Barbara. Secretary, Charles A. Preuss, 1317 Santa Barbara Street, Santa Barbara. Meeting, <i>Second Monday, Cottage Hospital.</i>
<b>Contra Costa County Medical Society</b> President, Joseph W. Boomer, American Trust Building, Richmond. Secretary, Henry W. McNeerney, 2600 McDonald Avenue, Richmond. Meeting, <i>Second Tuesday, 8:00 p. m.</i>	<b>Napa County Medical Society</b> President, Charles H. Bulson, 1203 Seminary Street, Napa. Secretary, M. M. Booth, Bruck Building, St. Helena. Meeting, <i>First Wednesday.</i>	<b>Santa Clara County Medical Association</b> President, Karl F. Pelkan, 903 Medico Building, San Jose. Secretary, Fred W. Borden, Sainte Claire Building, San Jose, 23.
<b>Fresno County Medical Society</b> President, John E. Young, Rowell Building, Fresno. Secretary, K. D. Luechauer, 1759 Fulton Street, Fresno. Meeting, <i>First Tuesday, University-Sequoia Club, Fresno.</i>	<b>Orange County Medical Association</b> President, L. F. Whittaker, 302 Third Street, Huntington Beach. Secretary, Russell I. Johnson, 181 Seventeenth Street, Westminster. Meeting, <i>First Tuesday, 7:00 p.m., Windsor Cafe, Santa Ana</i>	<b>Santa Cruz County Medical Society</b> President, Anton J. Sambuck, Union Street and Maple Avenue, Watsonville. Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz. Meetings: <i>February, April, October, and December. Time and place to be decided by the President.</i>
<b>Humboldt County Medical Society</b> President, Nathan G. Wasserman, 539 G Street, Eureka. Secretary, Joseph S. Woolford, 539 G Street, Eureka. Meeting, <i>First Thursday.</i>	<b>Placer-Nevada-Sierra County Medical Society</b> President, George A. Foster, Grass Valley. Secretary, Vernon W. Padgett, Grass Valley. Meeting, <i>At Call of President.</i>	<b>Shasta-Trinity County Medical Society</b> President, L. C. Mosher, Bieber. Secretary, Julius M. Kehoe, Redding. Meeting, <i>Second Monday.</i>
<b>Imperial County Medical Society</b> President, T. E. Bartholomew, 319 Third Street, Calexico. Secretary, Marian Hubbell, El Centro. Meeting, <i>Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.</i>	<b>Riverside County Medical Society</b> President, Omer W. Wheeler, 1939 La Cadena, Riverside. Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside. Meeting, <i>Second Monday, 8:00 p. m., Library, Riverside Community Hospital.</i>	<b>Siskiyou County Medical Society</b> President, H. L. Vidricksen, Weed Hospital, Weed. Secretary, F. W. Martin, Mt. Shasta. Meeting, <i>Sunday on Call.</i>
<b>Inyo-Mono County Medical Society</b> President, James Lloyd Mason, Bishop. Secretary, Walter L. Wilson, 108 N. Main, Bishop. Meeting, <i>Fourth Wednesday, except December, January, February.</i>	<b>Sacramento Society for Medical Improvement</b> President, Maurice A. Hopkins, Route 7, Box 1246A, Sacramento. Secretary, Edmund E. Simpson, 1127 Eleventh Street, Sacramento 14. Meeting, <i>Third Tuesday, 8:30 p. m., Auditorium, Sacramento.</i>	<b>Solano County Medical Society</b> President, H. Randall Madeley, P. O. Box 539, Vallejo. Secretary, John W. Green, Box 539, Vallejo, California. Meeting, <i>Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.</i>
<b>Kern County Medical Society</b> President, Sophie L. Goldman, 468 Habersfelde Building, Bakersfield. Secretary, Juliet Thorner, 109 Eighteenth Street, Bakersfield. Meeting, <i>Third Thursday, 7:30 p.m., Bakersfield Inn, except June, July, August.</i>	<b>San Benito County Medical Society</b> President, J. M. O'Donnell, Hollister. Secretary, J. J. Haruff, Hollister. Meeting, <i>At Call of President.</i>	<b>Sonoma County Medical Society</b> President, Kathleen G. Morris, 147 Kentucky Street, Petaluma. Secretary, Robert S. Quinn, 3325 Chanate Road, Santa Rosa. Meeting, <i>Second Thursday.</i>
<b>Kings County Medical Society</b> President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran. Secretary, Arthur Zeisner, 410 N. Irwin Street, Hanford. Meeting, <i>Second Monday, 8:00 p. m., Legion Hall, Hanford.</i>	<b>San Bernardino County Medical Society</b> President, J. J. H. Smith, 137 East H Street, Colton. Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino. Meeting, <i>First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.</i>	<b>Stanislaus County Medical Society</b> President, J. H. Czatt, 810 Fourteenth Street, Modesto. Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto. Meeting, <i>Second Friday, 7:30 p.m., Hotel Hughson.</i>
<b>Lassen-Plumas-Modoc County Medical Society</b> President, Fred J. Davis, Jr., 920 Pine Street, Susanville. Secretary, J. W. Crever, Susanville. Meeting, <i>On Call.</i>	<b>San Diego County Medical Society</b> President, George D. Huff, 806 Medical Building, San Diego 1. Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego, 1. Meeting, <i>Second Tuesday, University Club.</i>	<b>Tehama County Medical Society</b> President, James L. Faulkner, Red Bluff. Secretary, R. G. Frey, Red Bluff. Meeting, <i>At Call of President.</i>
<b>Los Angeles County Medical Association</b> 1925 Wilshire Boulevard, Los Angeles 5 President, J. Jay Crane, 418 South Arden Street, Los Angeles 5. Secretary, E. T. Remmen, 429 North Orange, Glendale 3. Meeting, <i>First and Third Thursday, 1925 Wilshire Boulevard, Los Angeles.</i>	<b>San Francisco County Medical Society</b> 2180 Washington Street 9 President, G. Dan Delprat, 384 Post Street, San Francisco 8. Secretary, Chester L. Cooley, 490 Post Street, San Francisco, 2. Meeting, <i>Second Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco, 9.</i>	<b>Tulare County Medical Society</b> President, Charles M. Mathias, 515 Kern Street, Tulare. Secretary, James C. Malcolm, 1501 West Main, Visalia.
<b>Marin County Medical Society</b> President, Alex Miller, 1010 B Street, San Rafael. Secretary, Carl W. Clark, 1010 B Street, San Rafael. Meeting, <i>Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.</i>	<b>San Joaquin County Medical Society</b> President, Yale Brody, Bank of America Building, Stockton 5. Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton 2. Meeting, <i>First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.</i>	<b>Ventura County Medical Society</b> President, Gerald K. Ridge, 704 East Santa Clara Street, Ventura. Secretary, George H. Arnold, Route 2, Box 12, Ventura. Meeting, <i>Second Tuesday, Ventura County Country Club.</i>
<b>Mendocino-Lake County Medical Society</b> President, J. E. Gardner, 215 W. Standley Street, Ukiah. Secretary, Dale E. Barber, Fort Bragg.	<b>San Luis Obispo County Medical Society</b> President, Edward C. Sherman, 784 Marsh Street, San Luis Obispo. Secretary, G. D. Kelker, 1114 Marsh Street, San Luis Obispo. Meeting, <i>Fourth Wednesday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.</i>	<b>Yolo County Medical Society</b> President, William J. Blevins, Sr., 212 Porter Building, Woodland. Secretary, Emery Leivers, Woodland Clinic, Woodland. Meeting, <i>First Wednesday.</i>
	<b>Yuba-Sutter-Colusa County Medical Society</b> President, Joseph D. Lewis, 423 Fourth Street, Marysville. Secretary, Thomas F. Keyes, 725 Fourth Street, Marysville. Meeting, <i>Second Wednesday.</i>	

(For roster of C.M.A. committees and other organization, see last month's issue.)



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#### California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrorse 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WEst 8000, Extension 75.

Barlow Medical Library (Los Angeles County Medical Association), 634 So. Westlake, Los Angeles 5. Phone Flitzroy 7694.

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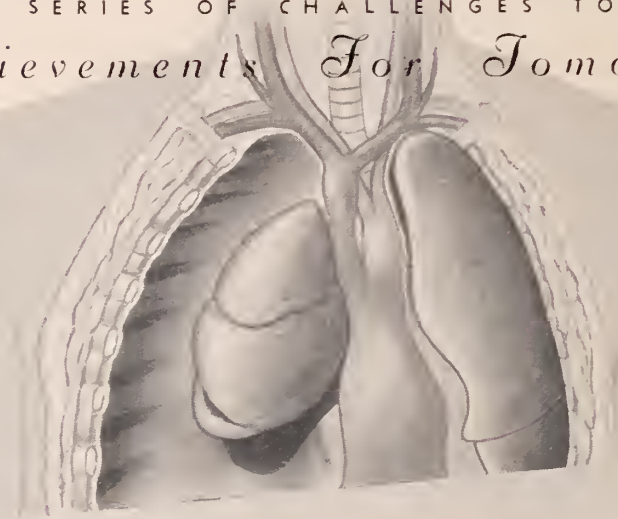
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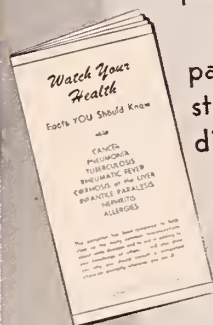
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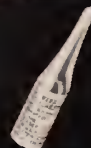
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## BOOK REVIEWS

### BOOKS RECEIVED

**What People Are: A Study of Normal Young Men.** By Clark W. Heath, In Collaboration with Lucien Brouha, Lewis W. Gregory, Carl C. Seltzer, Frederic L. Wells, and William L. Woods. The Grant Study, Department of Hygiene, Harvard University. Cloth. Price, \$2.00. Pp. 141. Cambridge, Massachusetts: Harvard University Press, 1945.

**Plaster of Paris Technique in the Treatment of Fractures and Other Injuries.** By T. B. Quigley, Lieutenant Colonel, Medical Corps, Army of the United States; Instructor in Surgery; Harvard Medical School (in absentia); Junior Associate in Surgery, Peter Bent Brigham Hospital, Boston (in absentia). Cloth. Price, \$3.50. Pp. 107, illustrated. New York: The MacMillan Company, 1945.

**Pulmonary Tuberculosis. A Handbook for Students and Practitioners.** By R. Y. Keers, M.D. (Edin.), F.R.F.P.S. (Glas.), Senior Physician and Medical Superintendent, Tor-na-Dee Sanatorium; Late Assistant Medical Superintendent, The British Sanatorium, Montana, Switzerland; First Assistant Medical Officer, King Edward VII Sanatorium, Midhurst; and B. G. Rigden, M.R.C.S. (Eng.), L.R.C.P. (Lond.), First Assistant Medical Officer, Tor-na-Dee Sanatorium; Late Resident Medical Officer, East Anglian Sanatorium, Nayland; Resident Medical Officer, Kelling Sanatorium, Holt, with a Foreword by F. H. Young, O.B.E., M.D. (Camb.), F.R.C.P. (Lond.), D.P.H., Physician, Brompton Hospital for Consumption and Diseases of the Chest; Consulting Physician, Charing Cross Hospital; Medical Officer in Charge of the Tuberculosis Dispensary, St. Bartholomew's

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**BOOKS RECEIVED**

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Hospital. Cloth. Price, \$5.00. Pp. 273, profusely illustrated. A William Wood Book, Baltimore; The Williams and Wilkins Company, 1945.

**Pediatric X-Ray Diagnosis.** A Textbook for Students and Practitioners of Pediatrics, Surgery and Radiology. By John Caffey, A.B., M.D., Associate Professor of Pediatrics, College of Physicians and Surgeons, Columbia University; Associate Pediatrician and Roentgenologist, Babies Hospital and Vanderbilt Clinic, New York City; Consulting Pediatrician, Grasslands Hospital, Westchester County, N. Y., and St. John's Hospital, Yonkers, N. Y. Cloth. Price, \$12.50. Pp. 838, illustrated. Chicago: The Year Book Publishers, Inc., 1945.

**One Hundred Years of Gynaecology: 1800-1900.** A Comprehensive Review of the Specialty During Its Greatest Century with Summaries and Case Reports of All Dis-

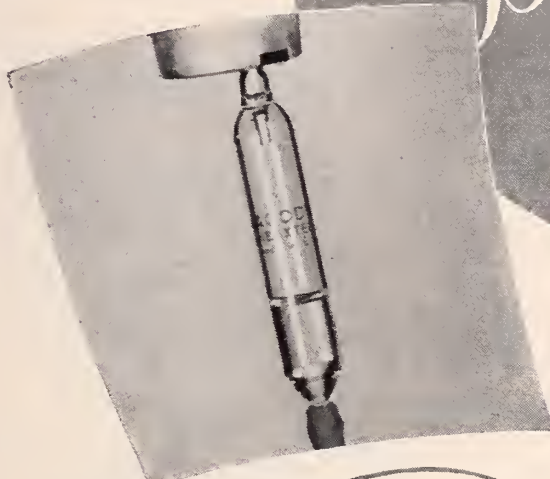
eases Pertaining to Women. By James V. Ricci, A.B., M.D., Clinical Professor of Gynaecology and Obstetrics, New York Medical College; Director of Gynaecology of the City Hospital, New York; Director of Gynaecology and Obstetrics, Columbus Hospital. Attending Gynaecologist and Obstetrician, Flower and Fifth Avenue Hospitals, New York; Consultant in Gynaecology and Obstetrics, Downtown Hospital, New York; Fellow of the New York Academy of Medicine. Department of Gynaecology and Obstetrics of the City Hospital, New York. Cloth. Price, \$8.50. Pp. 651. Philadelphia: The Blakiston Company, 1945.

**Textbook of Obstetrics.** Designed for the Use of Students and Practitioners. By Henricus J. Stander, M.D., F.A.C.S., Professor of Obstetrics and Gynecology, Cornell University Medical College; Obstetrician and Gynecologist-in-Chief, New York Hospital and Director of the Lying-In Hospital, New York City. Stander's Third Revision: This Edition represents the Ninth Edition of **Williams Obstetrics**, the first six of which were written by the late Dr. J. Whitridge Williams, Professor of

(Continued on Page 16)



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*Brucella melitensis* . . . 2000 million per cc.

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\*Staub, R. R.: Brucellosis, An Unrecognized Menace,  
*Northwest Med.*, 43:274-279 (Oct.), 1944.

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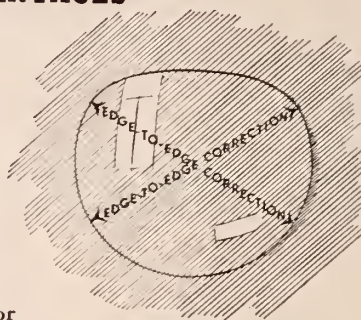
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It is well known that severely underfed patients with nutritional edema are excessively susceptible to infections, that infections superimposed on wasting diseases or marasmic states show a rapid, frequently fatal course. In the light of recent findings, both of these facts—heretofore but poorly understood—may well be on the way to conclusive explanation.\*

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Experimentally it has been demonstrated that induced hypoproteinemia reduces the capacity to produce agglutinins, precipitins, hemolysins. Adequate protein intake thus gains increasing significance as an essential factor in the resistance to infectious disease.

Among the protein foods of man meat ranks high, not only because of the percentage of proteins contained, but principally because its proteins are of high quality, able to satisfy every protein need.

*\*Cannon, P. J.: J. Am. Diet. Assn. 20:77 (1944)*

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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Kindergarten Through High School****INA M. RICHTER, M.D., Director****HAMILTON W. BINGHAM, Headmaster****BOOKS RECEIVED**

(Continued from Page 10)

Obstetrics, Johns Hopkins University School of Medicine; Obstetrician-in-Chief to the Johns Hopkins Hospital, Baltimore, Maryland. Cloth. Price, \$10.00. Pp. 1287, with 973 Illustrations on 740 Figures. New York, London: D. Appleton-Century Company, Incorporated, 1945.

**BOOK REVIEWS**

"Case Studies in the Psychopathology of Crime. A Reference Source for Research in Criminal Material." Volume Two, Cases 6-9. By Ben Karpman, M.D. Pp. 738. Station L, Washington, D.C.: Medical Science Press, 1944.

This is a voluminous book purported to be, except for grammatical and spelling corrections, written entirely by the subjects which it attempts to portray. The reviewer is first struck by the wide margins (1½ in.), great spaces between lines and the large print, and wonders if perhaps the paper shortage was more apparent than real.

The volume is the second of a group of "Case Studies in the Psychopathology of Crime." It is the only one of its kind ever written which delves so completely into the

life history of its patients and which is written entirely by them. The purpose of the present volume is to serve as a reference source for research in criminal material. It deals with four cases directly involving sexual crimes. The first is that of Walter Manson (Theft of the United States Mail; Drug Addiction); the second is that of Atkinson Cleary (Violation of the Mann Act); the third of Kenneth Elton (Rape); and the last is that of Jerry Biggs (Mail Train Robbery). The author's discussion is to be taken up later in a parallel volume of "The Individual Criminal."

The reviewer looks with a great deal of suspicion on the assertion by the author that adherence was made throughout to keep the original language of the patient-writer. All through the book one is struck by the discrepancy between the vocabulary of the patient and his education. Indeed some of the summations are quite erudite and display an insight into mental mechanisms that many psychiatrists lack. Yet, as in the case of Walter Manson, a drug addict, we have his own statement on page 277: "There is nothing in criminal history more mentally deteriorating than the use of narcotics." For an

(Continued on Page 17)

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**535 Powell Street  
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### BOOK REVIEWS

(Continued from Page 16)

individual who for many months used as high as 25 gr. morphine and 40 gr. cocaine daily, it indeed shows remarkable resistance and retention of mental faculties, particularly memory.

Even though the author admits a great deal of repetition, one can hardly excuse its presence thereby, since much of it could have been eliminated without destroying the context of the book. Many pages, except for a few words or phrases, are almost identical.

The sections on dreams included with each case are quite interesting. However, a great deal is undoubtedly lost without the author's interpretation in this volume. It is difficult for one too to appreciate the great amount of work and time most certainly involved. In fact the analysis of the dream life of Kenneth Elton, with his subsequent cure, appears to have been accomplished with such

case that one wonders whether an analyst was necessary at all to obtain the objectives.

In conclusion, nothing new is offered about the "psychopathology" of crime as the title would lead us to expect and so with the reading of the book we are no closer to the problem of the "whys" and "wherefores." Perhaps the succeeding volume will answer these questions.

On the whole, however, the book can be recommended for all of those interested in crime, for Dr. Karpman is eminent in his field and can be depended upon to have done the best possible with a most difficult subject.

J. PERLSON.

The marked reduction in birth rates in occupied Europe may be due to multiple causes, possibly quite remote from wartime undernutrition, but the increase in infant mortality rates, in infantile rickets, and in tuberculosis among children is probably related to undernutrition and malnutrition.—Foreign Letters, *J.A.M.A.*, May 6 and 27, 1944.

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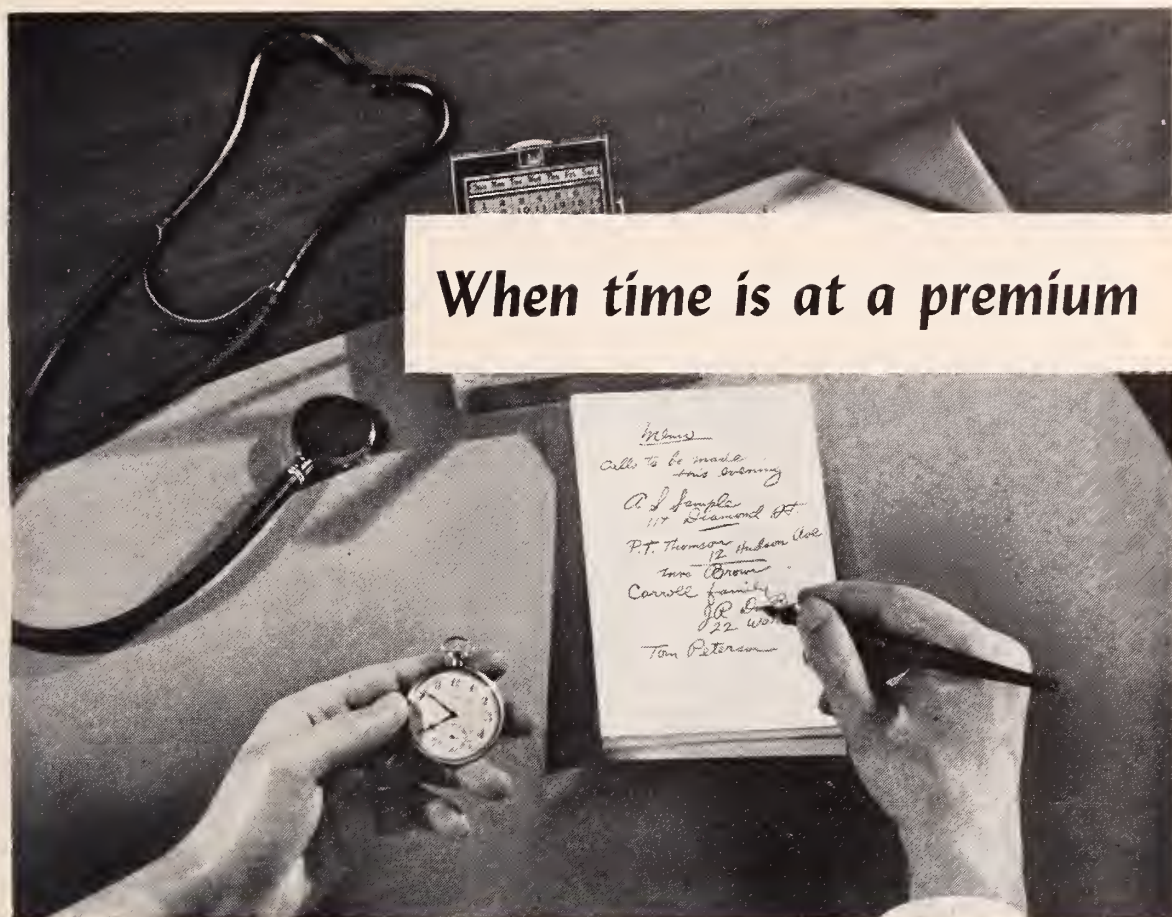
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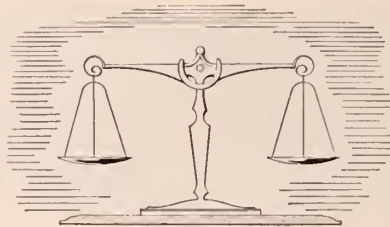
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#### TWENTY-FIVE YEARS AGO

(Continued from Text Page 258)

can he adapt himself to the case in hand. This is particularly true in the correction of nasal deformities; each case is a law unto itself, with its peculiar problem to handle. A congenital pug nose, and a depressed fracture of the bridge may appear to offer the same opportunities for the implantation of bone cartilage, but the one may need only the one procedure, whereas the other more than likely may require a resection of the septum, or a refracture of the maxillary bones. One patient may be perfectly willing to allow an injection of paraffine, whereas he might refuse absolutely the more major procedure of a rib transplant. . . .

*From an Article on "The Modern Treatment of Syphilis of the Central Nervous System," by H. G. Mehrtens, M.D., San Francisco. From the Neurological Clinic of Stanford University Medical School.—It is only in the last ten years that the treatment of syphilis of the central nervous system has differed materially from that employed for visceral lues. Even after it became known that drugs seldom penetrated the choreoid, the intravenous and intramuscular channels continued to be the main reliance. With these methods excellent results were obtained in some cases, while other cases were absolutely resistant. . . .*

*Excerpts from County Society Proceedings: Los Angeles County—County Medical Picnic.—The Council arranged a basket picnic, which was held at Sunland on the afternoon and evening of Saturday, September 11th. . .*

Dr. Duffield spoke last, but began by saying that the main object was fellowship and fraternity and to be-

come better acquainted with our folks and friends. He only referred to the problem, the serious thing, so as not to mar the pleasure of the day, and began to distribute the printed matter that was to familiarize us with the approaching storm, and although the sun was setting and the photographer would no longer be denied his needs, every member understood and is prepared to wage the war in defense of our dear ones at home and for the good of the people we serve. . . .

#### United Nations Relief and Rehabilitation Administration

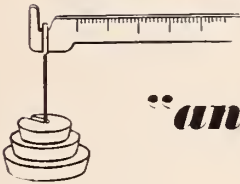
UNRRA has procured two million doses of typhus vaccine from the U. S. Typhus Commission for immunization of Displaced Persons in the United States occupation zone of Germany, according to word received at UNRRA's Washington headquarters from Lt. Colonel David C. Elliot of Cincinnati, U. S. Public Health Officer and UNRRA Chief Medical Officer for the zone.

Delivery of an extra one million doses is expected soon which, with stocks now on hand, will provide enough vaccine for a series of three Typhus inoculations to one million D.P.'s. There are 639,000 D.P.'s remaining in the United States zone, with added numbers expected to enter assembly centers during the winter.

Inoculation of children against diphtheria already has begun and will be completed by mid-November. Enough material to inoculate 35,000 to 45,000 children has been drawn from German and American sources. Stocks sufficient to inoculate 50,000 additional D. P. children have been requested from American sources. Adequate supplies of smallpox vaccine and typhoid vaccine are on hand and are being administered now by assembly center team doctors, Colonel Elliot said.

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Three daily servings of Ovaltine, each made of  
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PROTEIN . . . . .	31.2 Gm.	VITAMIN A . . . . .	2953 I.U.
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\*Based on average reported values for milk.



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for baby  
can be thankful for"  
*Continuity...* saves valuable time  
of feeding for the busy physician



Powder  
and  
Liquid



**M**ost pleasing, although seldom mentioned, are the many letters we receive from mothers praising their physicians for prescribing Baker's Modified Milk. Typical of such letters is one recently received which emphasizes an outstanding efficacy of Baker's: "Baby's excellent regularity is something to be thankful for."

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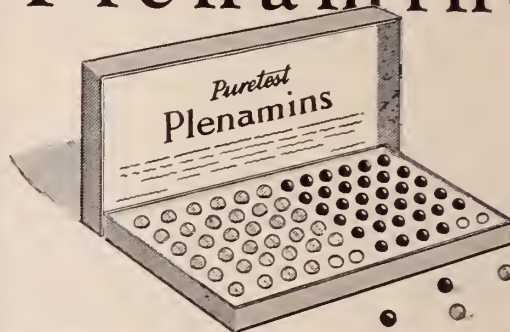
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### BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 258)

seized in the raid and in 1938 a case against her was dismissed because none of her alleged 'customers' would sign a complaint against her. . . . District Attorney Edmund G. Brown last night was not certain whether or not the woman who made the original complaint would sign charges against Mrs. Burns. Convictions for abortion, officials say, are difficult to obtain because publicity-shy victims hesitate to bring charges. . . . Following one of her earlier arrests, an investigator estimated her income at 'about \$1,000 a day' and the Federal Government said that her 1934 income from her 'profession' alone was \$43,533.56." (San Francisco Chronicle, Sept. 27, 1945.)

gation of a Long Beach health and patent medicine racket today. Authorities who arrested four men in the case said the headquarters on the Long Beach pike displayed the monster as a 'come on' in the sale of cure-all 'medicines.' They also disclosed that phonograph recordings of the quartet's spiel will be introduced as evidence at their trial on charges of violating state pure drugs, pharmacy, medical practice and chiropractic laws. Awaiting arraignment Monday are Dr. J. Edward Malone, chiropractor; William Rogers, 50, H. E. Haas, 55, and George W. Leffingwell, 50. Files found in their place of business indicated they did a nationwide mail order business in patent medicine, authorities said." (Los Angeles Daily News, Sept. 21, 1945.)

"A Gila monster poked its ugly head into the investi-

"A new hope for tuberculosis sufferers was announced  
(Continued in Back Advertising Section, Page 28)

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THE GUNS are silent once more. For the men with the guns, the war is over. But for the thousands of medical men in the service, the war still goes—their “war in white” in behalf of the wounded, the wearers of the Purple Heart. Doctors that they are, of medicine and morale, they well know how much a cigarette can mean to an invalid soldier. And servicemen that they are, as well, these doctors know what a big favorite Camels have been, and are, with men in all the services.

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Schieffelin BENZESTROL is available for oral, parenteral and local administration.

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5.0 mg. per cc 10 cc vials

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## BOARD OF MEDICAL EXAMINERS

(Continued from Page 24)

at the University of California, Los Angeles campus, yesterday. The hope centers in a bacillus extract called subtilin. It is derived from a bacterium called bacillus subtilis, which is found in the air, the soil and on plants, but is best known as the 'hay bacillus.' Thus far in experimental work subtilin's performance in some ways parallels and resembles that of penicillin, except that it is deadly to tuberculosis germs, which penicillin is not. It may be available for experimental work on humans as early as 'a month or so' hence. These were some of the aspects of the new extract as explained last night by Dr. Anthony J. Salle, associate professor of bacteriology at the university, in announcing subtilin. . . ." (Los Angeles Times, Sept. 14, 1945.)

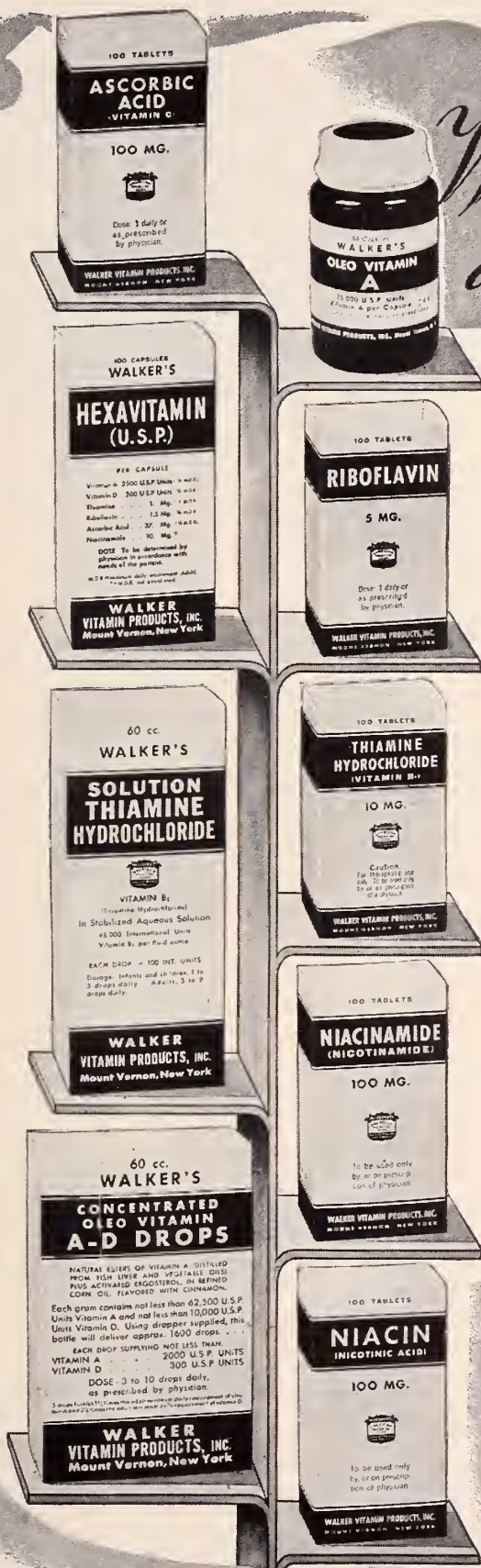
thropist, to aid research now under way at the University of California on prevention and control of epilepsy was announced today by Dr. Robert G. Sproul, president of the university. The money will be added to the Mother Lode Fund, which is supporting epilepsy studies in the department of neurology. The research program is directed by William J. Kerr of the University's Medical School in San Francisco." (San Francisco News, Sept. 18, 1945.)

Routine x-rays of patients, nurses, and other hospital employees will not only disclose unsuspected tuberculosis which is extremely important to the individual, but will also protect other patients and employees from the danger of infection. As more and more states are making tuberculosis a compensable disease, this factor will become increasingly important to hospital administration.—Karl H. Pfeutze, M.D., Mineral Springs San., Canon Falls, Minn.

"A grant of \$9,000 from C. S. Morse, local philan-

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**CASE HISTORY**

Record No. 135

Name Richard H. Poe

Address 123 S. Main Street

Dr. John J. Doe

FINAL DIAGNOSIS Hemiplegia

Date June 15, 1946

FOLLOW UP RECORD Par in region of infection improved

RESULT Recovered — Improved — Unimproved — Died

PERSONAL: Age 28 Sex Male E. M. W. D. Occupation Accountant

FAMILY HISTORY: Negative

HABITS: Non

PAST HEALTH: Us

PRESENT CONDITK on rig

PHYSICAL E 9

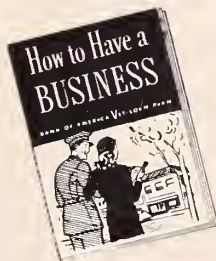
TEMP. 9

HEAD: (h) For

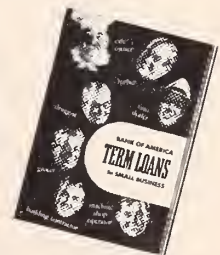
## CASE HISTORY OF THE DISCHARGED MAJOR—

Major ——— honorably discharged from Medical Corps last month on points. Found civilian office lacked several pieces of new equipment. Needed money for modernization. Was told at separation center of "G. I. Bill of Rights." Bill guarantees certain veteran loans up to 50% or \$2,000. Called on Bank of America and found complete lending service, offering sound statewide credit. Was extended credit under Bank of America *Vet-loan Plan* totaling \$3,100. Immediately purchased new equipment, refurbished office. Monthly *Vet-loan* payments arranged, consistent with ability to pay.

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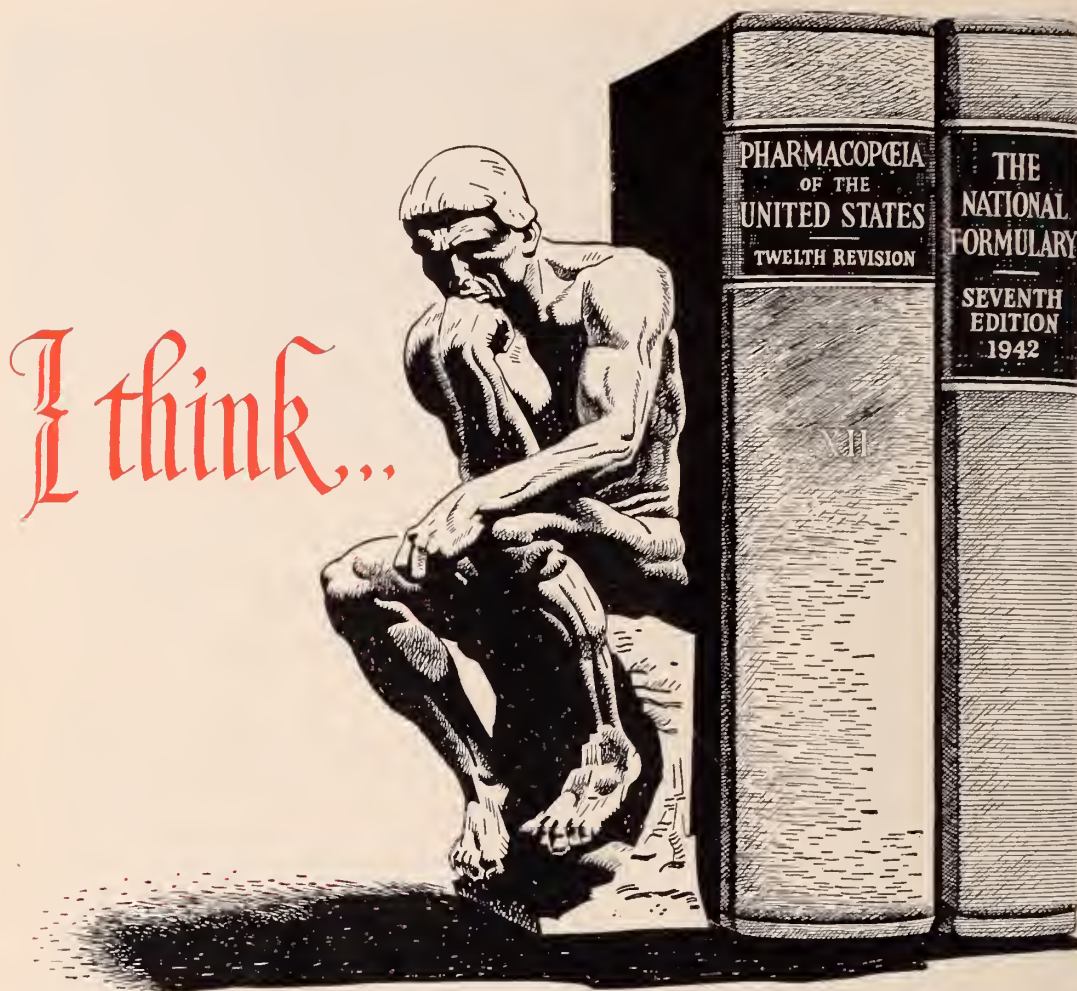
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# CALIFORNIA AND WESTERN MEDICINE

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EDITOR . . . . . GEORGE H. KRESS, M. D.

*Editorial Board*

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

*Committee on Publications*

George W. Walker, Chairman.....	Fresno	1946
F. Burton Jones.....	Vallejo	1947
R. H. Sundberg.....	San Diego	1948
George H. Kress, Secretary-Editor.....	San Francisco	ex officio

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*Change of Address.*—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

*Responsibility for Statements and Conclusions in Original Articles.*—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

*Contributions—Exclusive Publication.*—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

*Contributions—Length of Articles: Extra Costs.*—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

*Leaflet Regarding Rules of Publication.*—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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## EDITORIALS

### ON RE-LOCATION OF PHYSICIANS IN CALIFORNIA—IMPORTANT POLICY OUTLINED BY CALIFORNIA POSTWAR PLANNING COMMITTEE, THE C.M.A. PROCUREMENT AND ASSIGNMENT COMMITTEE FOR PHYSICIANS, AND BY THE COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

**Location Problems Arising as Military Colleagues Are Mustered Out.**—As rapid demobilization of the Armed Forces continues, an increasing number of physicians on being mustered out, are returning to civilian practice. It is natural that the majority of these military colleagues should be putting to themselves such questions as:

"Now that I have been mustered out, where do I go from here?"

"In what place (state, city, town) can I locate myself, to best conserve and promote my professional and also my family and personal interests?"

"Shall I return to the place where I was formerly in practice, or shall I consider a different community, in either my former or in some other State?"

Questions such as these are not easily answered. They were serious problems at the end of World War I; and at the present time, with V-E and V-J days behind us, the more than 50,000 physicians who have been in service in the Armed Forces in World War II must come to decisions in these matters.

\* \* \*

**Organized Medicine is Also Confronted with Re-location Problems.**—Above, mention has been made of some of the decisions each returning military colleague must make from the standpoint of his individual relationships. However, the present postwar situation includes elements that extend beyond the personal.

Thus, Organized Medicine, acting through the constituent state units and county medical societies must also put to their members, questions, such as:

"Since, throughout the present World War, our Associations have assured military colleagues that their interests would be conserved and safeguarded by their civilian fellows, to what extent will our State and County Medical Societies now make good on these promises?"

Also,

"In what manner, can the State and County Societies, through the collective endeavor of their

members, render the best aid to these brother physicians who are now returning to civilian practice; in the efforts of the latter again to build up practices, of nature and amount sufficient to meet immediate family and other needs, as well as lay foundations for future progress?"

\* \* \*

**Principles and Policies as Approved by C.M.A. Postwar Planning Committee and Council.**—It is of these and associated problems now confronting Organized Medicine that comment is here made.

The task is made much easier for the OFFICIAL JOURNAL, since what may be called the California policy in these matters was outlined at a meeting of the C.M.A. Council held on October 21, 1945, in Los Angeles.

At that meeting the Council heard and considered a report given by its C.M.A. Postwar Planning Committee and the California Procurement and Assignment Committee for Physicians, submitted by P. A. Chairman Harold A. Fletcher.

The report was approved and should be carefully read by every C.M.A. member, since the principles and policies outlined therein are a joint responsibility, in which:

- (a) Physicians in civilian practice,
- (b) Other physicians recently demobilized, and
- (c) Others who still remain in military service, must join in mutual respect and effort to promote the proper interests of all concerned.

The report referred to appears in this issue of CALIFORNIA AND WESTERN MEDICINE, on page 228.

\* \* \*

**Basis of Action Taken by the Council.**—Brief reference to conditions related to these matters and now confronting the California Medical Association and its County Societies may here be made. It is to be hoped that the justice of the decisions that have been reached will appeal to all physicians returning from military service, and who may be contemplating the establishment of themselves in civilian practice in one of the cities or communities of California.

One approach to a discussion of the California problems is to remember that returning military colleagues who left civilian practice to enter the Medical Corps of Army or Navy may be said to consist of two major groups:

(1) California physician licentiates who were established in civilian practice in communities in this State at the time they entered military service; and

(2) Physicians who left civilian practices in other States to enter military service, but who would now prefer, in reestablishing themselves, to take up medical practice in some place in California.

\* \* \*

**Nature of C.M.A. Request to its Own Returning California Military Colleagues.**—The constituted authorities of the California Medical Association and the California P. and A. Committee for Physicians are asking all former Califor-

nia licentiates, (that is, for the time being and until demobilization is practically complete), to resume civilian practice in the same communities where they were established at the time they entered the Army or Navy. For, in their former communities, their fellow physicians and former patients and friends can the more easily cooperate in reestablishment of practice, without hardship or infringement on the rights of other military colleagues from the same communities, who may still be in service.

California physicians returning now from military duty, who would prefer some city or community other than that in which they formerly practiced, should understand that they could render a real disservice to some brother physician still in service, who was looking forward to the time when he could return to his pre-war location, then only to learn that his place had been preempted in part by a brother physician of his own State.

The justice of this request that each Doctor of Medicine (at least tentatively and temporarily) go back to his former seat of practice in California, should be apparent.

\* \* \*

**Applicability of Principles Involved to Out-of-State Colleagues.**—Having indicated a rule of conduct that it is hoped California physicians will follow, in relation to the ethical rights and obligations to fellow California physicians still in military service, it is now in order to make comment concerning returning military physicians formerly in practice in other States, who would much prefer, when they again take up civilian practice, to establish themselves in a California city or community.

What has been said concerning the duty of a California physician coming out of Army or Navy may be said to apply with even more force to colleagues who were formerly in practice in other States, and who now aspire to California licensure and establishment of a medical practice in this State.

Of such, the number is not now in tens, nor even in hundreds. In fact, the figure of ten thousand physicians who are in military service and who hope to settle in California, has been given!

Certainly, half of that number, self-understandingly, would have a demoralizing effect upon medical practice in California!

But even if there were physicians in only tens or hundreds, the principles and policies outlined in the Postwar Planning Committee's statement and what has been above outlined, would still apply.

\* \* \*

**Location Problems Arise in All States—Fair Play to Colleagues Who Remain in Service Must be Maintained.**—These Other-State physicians,—who, like California physicians who have been in military service have rendered noble aid to our soldiers and sailors,—could be confronted in the States in which they formerly practiced with situations exactly such as have arisen in many places in California.



Each of such Out-of-State physicians could properly ask himself this question:

"What would be my reaction if, on getting out of service, I went back to my former city or community of practice, to find that I would be in competition, not only with my former colleagues, but with a half-dozen or more new men from other in- or extra-state locations; who, while I have been in service, have been establishing themselves where I thought I might again take up my life work, without the travail such as I experienced during the years when I first went into civilian practice?"

\* \* \*

Another group of military colleagues deserving of special consideration are those young physicians who were inducted into Army and Navy before they had ever established themselves in civilian practice. The procedure in regard to this group is indicated under Item 4 of the report, to which reference has been made. See in this issue, on page 229.

\* \* \*

**Moral and Other Suasion.**—From what has been said, and what is so well outlined in Chairman Fletcher's report, it should not be difficult to agree that we deal here with what may be termed ethical principles and fair dealing, associated with special obligations to colleagues, who, having given their all through military service, should now have certain preferences or rights when they seek, as may be stated, to "get back their jobs in their former locations."

The C.M.A. Postwar Planning Committee report indicates along what lines the objectives mentioned above are to be implemented. That is the reason the report should be read by every C.M.A. member.

\* \* \*

**Procurement and Assignment Committees are Still Functioning.**—The California and County Committees on Procurement and Assignment for Physicians are still functioning, and in these new problems in civilian practice, (just as in the last five years in military service) these Committees will decide whether a physician is "essential or non-essential" for a particular community.

If a physician is deemed non-essential for civilian practice in a certain community, a committee of the county medical society should meet with him, and courteously and diplomatically explain the local situation. Every county medical society in California should appoint such a committee.\*

To put it in other words, if a physician who has been declared "non-essential" to a community,—(be he a former Californian or from some other State)—but who, nevertheless, insists on estab-

lishing himself, he would probably in due time learn, in taking such a course, he had surrounded himself with isolation barriers that would not have become operative had he returned to his pre-war location; and of a nature that might seriously handicap him in his professional and other advancement.

\* \* \*

**Publicity Concerning These C.M.A. Policies is Desirable.**—Copies of the C.M.A. Postwar Planning Committee report have been forwarded to the Secretary of the American Medical Association, with the suggestion that proper publicity be given thereto in the *Journal of the American Medical Association*, so that physicians elsewhere may be in better position to orient themselves concerning the medical practice situation in California.

If physicians, both in military service and civilian practice, adequately understand the problems, coöperation may be expected, and the rights of all will be promoted to best advantage.

#### CALIFORNIA MEDICAL ASSOCIATION WILL HOLD ITS 75TH ANNUAL SESSION IN LOS ANGELES—A.M.A. IN SAN FRANCISCO IN 1946

**The Next C.M.A. Annual Session Will be Held on May 7-8-9-10, 1946.**—At the 329th meeting of the C.M.A. Council, held in Los Angeles on October 21st, it was voted to make next year's annual session, a regular four-day meeting.

Hotel Biltmore in Los Angeles will again be the headquarters (Hotel Del Monte at Monterey is still in possession of the Navy).

Meetings will begin on Tuesday, May 7, 1946 and continue through Friday noon, May 10.

Owing to crowded hotel accommodations, and because of existing conditions in civilian and military practice, no scientific exhibits will be shown.

However, commercial and technical exhibits will be displayed.

Members of the California Medical Association are requested to make notes of the days on their appointment books, and to arrange professional schedules and appointments, to permit attendance at some, if not all meetings.

Section officers, who will be happy to receive suggestions from civilian and military colleagues in California concerning topics for individual papers, symposia and panel conferences, may be addressed direct, or through the Association Secretary, who through by-law provision, is chairman of the Committee on Scientific Work that has charge of the coördination of programs of general and section meetings.

\* \* \*

**A.M.A. House of Delegates will meet in Chicago in December, 1945. Next Regular Session in San Francisco in 1946. Date to be Selected Later.**—The American Medical Association will hold no scientific assemblies or meetings in the present year, 1945.

\* On methods of procedure that County Medical Society P. and A. Committees could use to advantage, see in this issue the letter of the Chairman of the Santa Clara County Medical Society P. and A. Committee, on page 229.

However, the A.M.A. House of Delegates will convene in Chicago on Monday, December 3, and hold meetings through Thursday, December 6, 1945.

Unless present plans go awry, the next general meeting of the American Medical Association will be held in 1946 in San Francisco, the tentative time being set for days in either July or August, 1946. By then, the major transportation difficulties, so much in evidence at the present time, should have abated.

It is possible that definite dates for the 1946 A.M.A. meeting in San Francisco may be set by the A.M.A. House of Delegates when it convenes in Chicago in December next.

Members of the California Medical Association are urged to keep these coming meetings in mind, and if possible to be present in person.

#### UNIVERSITY OF CALIFORNIA WILL ESTABLISH A MEDICAL SCHOOL IN LOS ANGELES

**University of California at Los Angeles (U.C.L.A.) to be Given a Medical Department.**—With little forewarning or preliminary general discussion, came the announcement in California newspapers on October 20, that the Regents of the University of California, at a meeting held on the previous day at the campus of University of California in Los Angeles, had adopted the following resolution:

**MEDICAL SCHOOL—UNIVERSITY OF CALIFORNIA, LOS ANGELES:**

The Committee on Southern California Schools, Colleges, and Institutions recommended the adoption of the following resolution:

"WHEREAS, There now exists throughout Southern California an urgent need for a medical school as a part of the educational system of the University of California; now, therefore, be it

"Resolved, That the Board of Regents forthwith establish a school of medicine in Los Angeles, and the President of the University is authorized and directed to take such action as may be necessary or proper to that end, including a request to the Governor that adequate budget provisions for that purpose be submitted to the legislature at its next meeting, whether special or regular, and that the legislature be urged to appropriate the necessary funds."

On motion the Board adopted the recommendation of the Committee on Southern California Schools, Colleges, and Institutions as set forth above.

A newspaper item referring to the above appears in this issue of CALIFORNIA AND WESTERN MEDICINE, on page 234.

\* \* \*

**Initial Committee to Outline Plans for the School Has Been Appointed.**—To put in effect the resolution of the Regents, University of California President Robert G. Sproul has appointed a committee consisting of faculty members from the Berkeley, San Francisco and Los Angeles campuses. Early in November this Committee will meet and discuss some of the essential groundwork of the proposed medical school in

Los Angeles, that would be operated as one of the Southern California departments, and of which division, Dr. Clarence A. Dykstra, (former president of the University of Wisconsin), is now the head, in his position as Vice-President and Provost of the University.

\* \* \*

**Legislative Appropriation Will be Needed.**—Just when the new school will be started is not known at this time, since a special legislative appropriation will be needed to inaugurate the work.

It may be assumed,—as has been the case with other medical schools that have come into existence in recent years—that the new School of Medicine, U. of C., will begin its work with a single freshman class, say of 60 students; in each succeeding year a new freshman class being enrolled, so that at the end of four years, a full four year course would be in operation.

\* \* \*

**Los Angeles Has Ample Clinical Facilities for Three Medical Schools.**—Los Angeles, with its population of almost two million persons, at the present time is the seat of two undergraduate medical schools: University of Southern California School of Medicine, and the College of Medical Evangelists. The clinical facilities available in Los Angeles are ample to supply the needs of three Class A medical schools.

The addition of the proposed Los Angeles Medical School of the University of California would give an impetus and make for increased interest in medical study and research, and be a distinct and helpful aid in the promotion of health, and the prevention and cure of disease in our State.

It is to be hoped that the initial plans for the new school will go on to happy fruition.

#### MEDICAL EPONYM

##### *Wernicke's Disease*

The original account of this condition, by Carl W. Wernicke (1848-1905), at that time *Privat-dozent* at the University of Berlin, appears in his *Lehrbuch der Gehirnkrankheiten für Aerzte und Studierende* (Kassel and Berlin, 1881: Vol. II, pages 229 to 242), under the title "Die acute, hämorrhagische Poliencephalitis superior [Acute Hemorrhagic Superior Polioencephalitis]." A portion of the translation follows:

"We are here dealing with an independent inflammatory, acute disease of the nuclei of the nerves supplying the eye muscles, which results in death within a period of ten to fourteen days. The localizing symptoms consist in associated ocular muscle palsies, which appear suddenly, progress and lead finally to almost complete paralysis of the eye muscles. Certain muscles, however, such as the sphincter iridis or the levator palpebrarum, are spared. The patients' gait become uncertain, showing a combination of stiffness with ataxia, usually suggesting the ataxia of the alcoholic. The general symptoms are striking, and consist in disturbances of consciousness, either somnolence from the outset, or an end stage of somnolence introduced by a more prolonged period of agitation. Further, in all 3 cases there was involvement of the optic nerve, consisting of inflammatory changes in the papilla." —R. W. B. in *The New England Journal of Medicine*.



## EDITORIAL COMMENT †

## POTENTIATED MALARIA AND INFLUENZA VACCINES

Theoretical interest in substances that increase and prolong specific antibody production can be dated from Burky's<sup>1</sup> study of the antigenicity of homologous lens proteins. Previous work had shown that it is almost impossible to sensitize or immunize laboratory animals by injections of lens proteins from the same animal species. Burky, however, found that rabbits are readily sensitized or immunized by the injection of homologous lens substance mixed with, or simultaneously with, staphylococcus filtrate.

Since then numerous other immunologic "adjuvants" or "maximizers" have been studied, such as lanolin, calcium chloride and tapioca. Particular interest has centered on emulsions of lanolin-like substances in mineral oil, with or without the addition of killed acid-fast bacteria. Freund<sup>2</sup> and his associates of the Bureau of Laboratories, New York City, found that this mixture enhances and prolongs specific antibody production against horse serum, diphtheria toxoid, *B. typhosum*, and many other antigens. The lanolin-like substance used by him was usually "Falba," a commercial adsorption base, said to be a mixture of oxycholesterins and cholesterins derived from lanolin.

Early investigators<sup>3</sup> had found that it is almost impossible to immunize laboratory animals against malaria infections by inoculations with killed malaria parasites. In his latest work, Freund<sup>4</sup> attempted to potentiate this ineffective vaccine by means of his Falba-mineral oil mixture. Highly parasitized duck red blood cells, containing approximately 100 malaria parasites (*P. lophurae*) per 100 r.b.c., were suspended in saline solution containing 0.1 per cent formaldehyde. The suspensions were kept at 4° C. overnight and then washed three times with formaldehyde-free saline solution. One part of the washed cells was then emulsified with one part Falba plus one and one-half parts mineral oil containing killed and dried tubercle bacilli.

The emulsified vaccine was injected subcutaneously or intramuscularly at four week intervals in divided doses into two months old white Pekin ducks. About one month after the last injection, the vaccinated ducks and an equal number of non-vaccinated controls were each injected intravenously with approximately one billion living malaria parasites (*P. lophurae*). Each of the immunized ducks had approximately one circulating malaria parasite per 100 r.b.c., for six to seven days after the injection, after which the blood became and remained sterile. In contrast, the blood counts in the non-vaccinated controls increased rapidly after

the third day, reaching between 100 to 150 parasites per 100 r.b.c., before the death of the animals. Death usually occurred between the 10th and 12th day.

Practically the same degree of immunity was shown by monkeys vaccinated with killed highly virulent *P. knowlesi* emulsified in the same Falba-mineral oil mixture. Here a slight proliferation of the intravenously injected test dose occurred in about half of the vaccinated monkeys. All but one of them, however, became free from circulating parasites by the 18th to 21st day. Marked proliferation took place in the non-vaccinated controls. The count often reached 50 or more parasites per 100 r.b.c. before the death of the animal. Death usually occurred between the 9th and 14th day.

Palpable masses were found in the subcutaneous tissues at the site of injection in all vaccinated monkeys. These masses did not ulcerate through the skin in monkeys, which showed no reaction to tuberculin. Abscess formation and ulceration, however, did take place in all tuberculin positive monkeys. Freund believes that such ulceration could be prevented by omitting or substituting timothy-grass bacilli for the tubercle bacilli in his Falba-mineral oil mixture.

In 1944, Friedewald,<sup>5</sup> of the International Health Division, Rockefeller Foundation, tested the potentiating effects of the same adjuvants on influenza vaccine. He found that control subcutaneous injections of allantoic fluid virus concentrate induced serum antibodies in experimental animals. The maximum titer was reached within two weeks, after which the titer gradually fell, reaching practically zero by the end of twelve weeks. The addition of killed acid-fast bacteria (*Myco. tuberculosis* or *butyricum*), mineral oil and Falba, to form a stable water-in-oil emulsion of the influenza virus, increased antibody production at least eight-fold. At least four times the maximum control titer persisted for at least six months. *Myco. butyricum* was found to be more effective than the tubercle bacillus in this mixture. Mineral oil without Falba was only half as effective.

Clinical tests of similarly potentiated influenza vaccines are currently reported by the Henles<sup>6</sup> of the Department of Pediatrics, University of Pennsylvania. Centrifuged concentrates of types A and B influenza vaccines were divided into two parts. One-half of each vaccine was emulsified in one part Falba plus four parts mineral oil, but without acid-fast bacteria. The other half of each vaccine was diluted with four parts of buffered salt solution, to serve as a control. Eighty female patients were injected subcutaneously with 0.3 cc. of the emulsified vaccine, and 80 additional patients with the non-emulsified saline control.

Following administration of the saline control, the antibody titer reached a maximum of about 250 Hirst<sup>7</sup> units by the end of two weeks, and then fell to but slightly above the minimum prophylactic titer (128 Hirst units) by the end of three months. With the Falba-mineral oil emulsion, the titer continued to rise for about three

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

months, at which time it reached 750 Hirst units. The titer then fell gradually to about 600 units by the end of six months. At this time it was about 4.5 times the saline control titer. Prolonging the curve, one might predict that the emulsified vaccine would, presumably, be prophylactically effective for at least two years.

Nodules of varying dimensions could be palpated in the subcutaneous tissues of most patients given the Falba-mineral oil emulsion. Most of the nodules disappeared spontaneously before the end of the experiment. In only two of the 80 patients was there abscess formation, only one of which required surgical treatment.

No fully satisfactory theory has thus far been proposed to account for the immuno-potentiating effect of the Falba-mineral oil mixture. It is evident, however, that this mixture is of sufficient clinical promise to warrant its research application to numerous other relatively ineffective prophylactic or therapeutic antigens.

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### VECTORS OF TSUTSUGAMUSHI DISEASE (SCRUB TYPHUS)

Early in the war with Japan, a commission was formed under the chairmanship of Blake<sup>1</sup> of Yale University to investigate tsutsugamushi disease (scrub typhus or "dangerous-bug" fever) in the New Guinea area. Earlier investigators<sup>2</sup> had shown that *Rickettsia orientalis* is the causative agent of this disease. Rats were suspected as being the main environmental host with various species of mites as the presumptive intermediary vectors. This epidemiologic theory, however, was based solely on circumstantial evidence. Up to the time of appointment of the commission, investigators had failed to bring experimental proof of the presence of *Rickettsia orientalis* in mites recovered from endemic areas.

Now some of the missing evidence has been supplied. Larval forms of mites were collected in the Buna area from the skin and boots of men who had been exposed in the field, and from 55 rats and 28 bandicoots captured in the vicinity. About 90 per cent of the mites thus collected belonged to a single species, *Trombicula fletcheri*. Eight pools of from 150 to 200 *T. fletcheri* (7 from bandicoots and 1 from a rat) were emulsified and injected intraperitoneally into groups of four mice. Each group received the emulsion from a single animal. The results with six groups

were negative. Two groups, however, showed positive *R. orientalis* infection. Both were from bandicoots.

The rickettsial strains originating from these two pools were continued by serial passage in mice and compared with strains recovered by inoculating mice with blood of local patients suffering from tsutsugamushi disease. Immunity tests between the two mite strains and strains of human origin carried out in rabbits, hamsters and Swiss mice indicated complete cross protection. The human and mite strains were otherwise identical and exhibited all of the characteristics of *R. orientalis*.

Brain tissues from both bandicoots were injected into mice with negative results. Up to this time, therefore, there is no convincing evidence that the bandicoot is a reservoir host. Since *R. orientalis* may be passed in mites from one generation to the next, the infection in the mites recovered from bandicoots might have originated in a previous larval generation feeding on rats or on some other animal species.

While *Trombicula fletcheri* is presumably the dominant vector of scrub typhus in the New Guinea area, other mite species may play a dominant rôle in other parts of the Pacific.

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### Huge Atom Research Purchasing Revealed

Recent award of the Army-Navy "E" to the University of California Los Alamos Scientific Laboratory in New Mexico also covered the operation of a huge purchasing office in Los Angeles, which is now revealed to have spent millions of dollars in the last few years in providing atom bomb researchers with over 100,000 different items of material and equipment.

Paralleling the race of university scientists to find the secret of atomic energy before it could be discovered by enemy powers was the race of University buyers to supply the experimenters with many unusual and urgently needed items.

Every modern technique of expediting procurement and delivery was employed. In some instances bulky shipments were transported by attaching freight cars to crack passenger trains. Air transport was used whenever possible; one product was flown by special plane from Great Britain to California.

To speed delivery and at the same time maintain secrecy about the project, the University established merchandise-assembling warehouses throughout the country, from which equipment was transshipped to the laboratories. Before merchandise left these warehouses, all markings identifying it with the University were removed.

Because of the secrecy of the project, University purchasing agents were not allowed to reveal their connection with the Army when placing their orders, and this often caused manufacturers and suppliers to be amazed at the unusual products bought in the name of the University.



## ORIGINAL ARTICLES

## Scientific and General

## PUBLIC HEALTH AND PREVENTIVE ASPECTS OF STREPTOCOCCAL INFECTIONS\*

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MANY aspects of respiratory infection by hemolytic streptococci have become better understood during the last ten years. The development of technique for the serological classification of these organisms has implemented clinical and epidemiological studies of great importance. A variety of immunological procedures have also contributed valuable information. The rapid mobilization of troops in the present war led to outbreaks of streptococcal infection in certain areas which permitted the establishment of comprehensive programs for the study of the nature of disease caused by these organisms and its control.

## STUDIES MADE DURING LAST DECADE

The results of the work of the last decade may be summarized: 1. Hemolytic streptococcal respiratory infections are nearly always caused by organisms that are members of a single serological group, designated by the letter "A".<sup>1</sup> A large number of types have been identified within this group. When typing<sup>2</sup> is performed, it is discovered that, during any season in any community, a relatively small number of different types will be responsible for nearly all infections, both respiratory and non-respiratory.

2. There is no essential difference between hemolytic streptococcal sore throat with (scarlet fever) and without rash. It is true that the average example of the former disease is somewhat more ill than the latter, but there is much overlapping. The incidence of serious complications is similar in both types of disease. Recent studies indicate that there are many types or strains of streptococci that are unable to induce rash formation in susceptible individuals, but do produce important and disabling disease. Because of this fact, and because many individuals have immunity to the erythrogenic toxin, infection without rash formation occurs much more frequently and is more important.

3. The character of hemolytic streptococcal respiratory disease is variable. In children less than two years of age it lacks the explosive qualities which it assumes in later life, tends to produce chronic suppurative processes, rash formation is uncommon, and arthritic complications are rare.<sup>3</sup> In older children and adults, streptococcal infection of the upper respiratory passages is often an acute febrile illness associated with exudative tonsillitis, redness and edema of the pharyngeal tissues, tender anterior cervical adenitis, leucocytosis, and a rapid erythrocyte sedimentation rate. Many atypical, mild, and even in-

apparent infections occur and it is quite possible that they are comparable in number with clinically recognizable cases.

4. Group A hemolytic streptococcal respiratory disease is frequently followed by non-suppurative complications that are probably the result of a complex immunological mechanism.<sup>4</sup> Approximately 20 per cent of infections in adults are followed by continuing disease processes. In some individuals the erythrocyte sedimentation rate remains rapid for several weeks, frequently with clinical evidence of continuing disease in the form of fever and malaise. Electrocardiographic evidence of carditis may be demonstrated in many of these cases. In a rather small group arthritis will appear in addition to the signs and symptoms just described. *A recent critical study<sup>4</sup> revealed that the syndrome usually described as 'rheumatic fever' occurred only as a sequel to infection by Group A hemolytic streptococci.* The results of these observations were summarized as follows:

"It seems quite impossible to establish adequate criteria for the accurate division of these various late complications of streptococcal disease into separate groups. Instances of carditis with and without arthritis must be regarded as comparable disorders, and both appear to be related to arthritic disease without carditis. Since arthritis has been demonstrated without carditis and the reverse, there appears to be no valid reason for concluding that examples of continuing disease in the absence of both of these clinical phenomena are unrelated to the first two types of disorder.

"Because of these difficulties, and because evidence of carditis, the most serious complication, was observed most frequently in the absence of arthritis, it would seem to be desirable to discourage the emphasis placed on the syndrome 'rheumatic fever' and to begin to think in terms of the complications occurring after streptococcal infection, which might well be called the 'post-streptococcal state.' Such disorders as 'rheumatic fever,' 'post-scarlatinal arthritis,' 'atypical rheumatic fever' and others, could be considered as a single entity. Furthermore the fact that serious non-arthritic complications may follow streptococcal infections would be emphasized."

The background just presented indicates the importance of hemolytic streptococcal respiratory infection. Much disability results from the acute illness and the suppurative complications which occasionally follow. Suitable therapy, when indicated, with penicillin or the sulfonamides may be expected to minimize this problem. No proved technique is yet available for the treatment of established hemolytic streptococcal infections which will prevent the development of the serious late non-suppurative complications that are so frequently followed by chronic valvular heart disease. Furthermore, the vast number of mild and inapparent infections will not ordinarily receive medical attention, but are potentially capable of inciting the most severe arthritic and non-arthritic complications.

It is clear, therefore, that the elimination of rheumatic fever and the related disorders associated with the post-streptococcal state requires, in the light of our present information, the complete suppression of infection of human beings by hemolytic streptococci. The magnitude of the national problem needs no additional emphasis when it is realized that streptococcal respiratory disease and its complications have been one of the principal causes of disability in many military training establishments, and that acute rheumatic fever and chronic valvular heart disease are, next to tuberculosis, the most frequent causes of death due to infectious disease among children and young adults.

Various techniques are of potential value in the prevention of infection by hemolytic streptococci which may

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Much of the information used in the preparation of this paper was obtained during field studies by the Commission on Hemolytic Streptococcal Infections and the Commission on Airborne Infections, Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army, Preventive Medicine Service, Office of the Surgeon General, U. S. Army.

be described and evaluated. They fall naturally into two groups.

#### PREVENTION OF TRANSMISSION

The most widely applied methods for the prevention of respiratory infections have been those designed to prevent the transmission of the etiological agent from the infected individual or healthy carrier to susceptible persons. These must be discussed with special reference to streptococcal disease.

1. *Isolation of Infected Cases.*—The isolation of individuals suffering from respiratory infections of all sorts as a control measure has, in general, failed to be of value. It has been particularly futile in relationship to streptococcal disease, since nearly all public health departments require the isolation of scarlet fever, but ignore the many examples of similar disease without rash that are fully capable of transmitting infection. When it is further understood that virulent organisms persist in the nasopharynx for many weeks after recovery, and that inapparent and unrecognized cases are very frequent, it is obvious that isolation of sick persons will not prevent the spread of streptococcal disease.

2. *Control of Carriers.*—The problems involved in the control of healthy carriers of Group A hemolytic streptococci become apparent when it is realized that from five to fifty per cent of all persons may harbor these organisms in the nasopharynx. The rate will vary with age, the presence or absence of tonsils, and the epidemic state of the community. No satisfactory procedure for the elimination of hemolytic streptococci from the throats of carriers has been devised. Sulfonamides and the local application of various antibiotics have not been useful. Prolonged administration of penicillin may be effective but is, as yet, extremely cumbersome. Other natural factors are at work, however, which in part reduce the hazard arising from the presence of large numbers of carriers. It is possible that the invasiveness of the organism may be reduced by prolonged residence in the throat, or by other unknown mechanisms. More important are recent observations<sup>5</sup> which indicate that individuals are "dangerous carriers" only if they harbor hemolytic streptococci in the nose. Such persons disseminate into their environment many more streptococci than do simple throat or tonsillar carriers. The elimination of nasal carriers from operating rooms, kitchens and other institutional situations may be of value.

3. *Sterilization of Air.*—Considerable evidence exists which suggests that hemolytic streptococci may be "air-borne" and produce infection at points remote from their source. If this is correct, it would be desirable to prevent such spread by removal of bacteria from the air. Three methods are available at present for this purpose.<sup>5</sup> One involves the reduction of air contamination by the oiling of floors and bedding. It has been demonstrated that it is possible to greatly decrease the number of bacteria including hemolytic streptococci that will be disseminated into the air from secondary extra human reservoirs during such activities as floor sweeping, bed making, and dressing.

Two techniques are also available for the sterilization of air. In one, the bactericidal properties of ultra-violet light are utilized; in the other, those of certain glycols that may be vaporized into the air.

All of these methods are under study at the present time and it is not yet possible to evaluate their effectiveness in the reduction of the transmission of streptococcal disease. It is quite apparent, however, that certain mechanical limitations to their usefulness exist. They are relatively cumbersome and expensive, and will probably only be applicable under circumstances in which numbers

of persons are congregated for work or amusement within enclosed spaces such as factories, theaters, auditoriums, ships, and in military establishments.

Most important, however, is the fact that the prevention or control of contamination of the air by hemolytic streptococci can not be expected to eliminate the transmission of disease by direct contacts between infected cases and carriers, and susceptible individuals.

#### PREVENTION OF TISSUE INVASION

Because the available methods do not eliminate the transmission of hemolytic streptococci from carriers and infected cases to the respiratory passages of susceptible human beings, it has been necessary to seek means for the prevention of tissue invasion and the establishment of disease by these organisms after they have reached the nasopharynx.

1. *Chemoprophylaxis.*—An extensive experience in civilian practice<sup>7</sup> and in the armed forces<sup>8,9</sup> had apparently established the effectiveness of sulfonamides as prophylactic agents for the prevention of hemolytic streptococcal respiratory disease. The daily administration of one gram of sulfadiazine almost completely eliminated this type of infection in a large group of highly susceptible military personnel and greatly reduced the frequency of occurrence of rheumatic fever. A similar program usually prevented recurrences of activity in children who had undergone previous attacks of acute rheumatic fever. Protection was presumably lost within a few days after the discontinuation of continuous chemoprophylaxis. More recent observations indicate that a considerable number of sulfonamide resistant strains of Group A hemolytic streptococci are prevalent in certain population groups and that their epidemic spread is not affected by chemoprophylaxis. The usefulness of this technique for the prevention of hemolytic streptococcal respiratory disease has not, therefore, been completely evaluated.

Toxic reactions, following the prolonged use of sulfonamide prophylaxis by the Navy, have been few. Approximately 0.5 per cent of adult males, who received one gram of sulfadiazine per day, developed a dermatitis which disappeared promptly when the drug was withdrawn. Serious complications, such as exfoliative dermatitis and granulocytopenia were observed in only 0.01 per cent. These untoward reactions were ordinarily reversible if no further sulfonamide was administered. These experiences make it proper to recommend sulfonamide prophylaxis under circumstances in which it is essential that hemolytic streptococcal respiratory infection be prevented, since the degree of protection may be high and the incidence of toxic reactions is low. Such situations will arise in the armed forces, in rheumatic subjects, in schools and institutions, and perhaps even in whole communities if streptococcal disease should become epidemic. The possible presence of sulfonamide resistant strains must be constantly borne in mind. The epidemic streptococci should be tested *in vitro* and chemoprophylaxis established only if the organisms are definitely inhibited by low concentrations of sulfonamides.

It is of great importance that sulfonamide prophylaxis never be undertaken unless all of the subjects receiving the drug are readily available for frequent examination by a physician. A careful history must be obtained and the drug withheld from all persons in whom evidence of a previous sulfonamide sensitivity is discovered.

2. *Biological prophylaxis.*—It does not seem probable that the most complete control of carriers and infected cases, and the most extensive application of air sterilization now anticipated, will result in a great reduction in the frequency of hemolytic streptococcal respiratory disease and its complications. The use of chemoprophylaxis



## CARCINOMA OF THE RECTUM\*

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is also impractical in other than selected and carefully controlled groups.

Some other method must therefore be sought which will raise the resistance of the individual to infection by streptococci. The establishment of active immunity by vaccines is an obvious possibility but is fraught with many difficulties. Considerable evidence exists to indicate that immunity is type-specific. Since many serological types are constantly causing disease, polyvalent vaccines would be required. It also seems quite possible that any increased resistance to infection would be short lived. There is, in addition, the real possibility that inoculation of human beings with these organisms would increase the streptococcal tissue sensitivity and enhance the opportunity for the development of post-streptococcal complications in such persons, if subsequent infection should occur.

The biological prevention of hemolytic streptococcal infection should certainly be explored, but it is unlikely that a satisfactory prophylactic technique will be established.

## SUMMARY

Respiratory disease caused by hemolytic streptococci is of extreme importance because disability results not only from the acute illness but also from the serious non-suppurative complications which frequently follow. Rheumatic fever is one of these but is only part of a complex pathological process initiated by infection by streptococci.

Measures for the prevention of transmission at the present time include isolation and control of infected cases and carriers, air sterilization, and chemoprophylaxis. Each of these is applicable only under special circumstances. No technique has been suggested which appears likely to succeed in the principal problem, which is the elimination of infection by streptococci from the whole population.

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## More Boys Than Girls Are Born During War

It is true that more boys than girls, proportionately, have been born in war years, particularly in the years after a war, according to Dr. George Wolff, U. S. Children's Bureau statistician, but why it is true nobody knows.

Dr. Wolff advances several theories. It may be that the younger age of the mothers has something to do with it since in war periods more people get married and at a younger age. Or it may be the younger age of the father or some other biological reason.

Normally, the sex ratio is between 105 and 106 boys born for every 100 girls. In war years the sex ratio may go up to 107 or 108, a rise sufficient to have significance. Among Negroes in the United States, the differential is less than for whites, only about 102 boys being born for every 100 girls.

OF the cancers of the body, cancer of the rectum ranks number four in frequency, and kills 9,000 persons every year in the United States, according to the Federal Bureau of Vital Statistics. There is an apparent, if not a true, increase in the incidence of cancer of the rectum. In the report of the Federal Bureau of Vital Statistics for the year 1882, which recorded 204 cases of deaths from cancer of the rectum, it is stated "cancer is a disease which is believed to be gradually increasing in frequency and causing a large proportion of deaths in those nations which are most advanced in civilization." In 1890 there were 574 deaths in ratio of 2 per 100,000 population. In 1940 the ratio was 6.7 per 100,000. The death rate is too high because too many patients receive treatment too late. The early lesion exhibits few, or no signs or symptoms, and the patient does not recognize gradual changes from his normal state of well being. The physician may fail to make a manual or proper sigmoidoscopic examination, may regard a negative finding from the barium enema as conclusive, make a diagnosis of diverticulitis, so-called "mucus colitis, amoebiasis, chronic ulcerative colitis, etc.," or give treatments of "shots" for hemorrhoids.

The majority of these patients with cancer are between the ages of 50 and 70, but 20 per cent occur before the age of 50. About 3 per cent occur between the ages of 20 and 30, and it is in this decade of life that they are most often overlooked. Cancer in the young, as a rule, is highly malignant, metastasizes rapidly and the majority of these individuals are inoperable when seen, or die with metastases.

## DIAGNOSIS

The common signs and symptoms are a change in bowel function, especially frequency, which is so often called diarrhoea, or dysentery, unsatisfied stool with blood or mucus, abdominal discomfort, and in some cases evidence of obstruction as increasing constipation. Pain is absent or late.

Proper palpation will reveal 80 per cent. The sigmoidoscopic examination will complete the diagnosis. The lesion may be a polyp or polypoid mass, a crater-like ulcer with firm margins, or an annular lesion involving all of the bowel. A biopsy specimen should be examined for confirmation, and if negative, should be repeated. Sigmoidoscopic examination should be done under intravenous anesthesia if the instrument cannot be passed to 8 inches, especially if blood is a constant finding. The negative opaque enema is valueless below 8 inches and may be dangerously misleading, because a filling defect is usually obscured by other loops of bowel, and for this reason should never be given preceding the sigmoidoscopic examination.

Microscopical grading of the specimen is valuable in adenomas, polyps, and villous papillomas. These are usually a Grade I, or pre-malignant, if not benign. The grading of frank adenocarcinomas should not influence the treatment because radical removal is indicated whether or not the Grade is II, III, or IV.

Differential diagnosis must be made from sarcomas (rare), metastasis from upper abdominal lesions (stomach, pancreas, ovary, uterus, bladder, colon), and prostate, from radium burn, and chronic infections as

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amoebic granulomas, lymphogranuloma inguinale, and chronic ulcerative colitis.

Anal cancers are usually epitheliomas, are painful ulcerating lesions, which may be mistaken for simple anal, tuberculous, or luetic ulcers.

#### TREATMENT

Operability and curability must be determined by an evaluation of all the factors concerned, as age and general condition of patient, type, size and location of growth, and the presence of metastasis. Small movable tumors are often more likely to spread early than those which have become surrounded by inflammatory tissue. Fixed tumors are often easily separated from surrounding tissues after the line of cleavage has been found.

The patient is entitled to every means for a cure, and should not be denied an exploratory procedure unless utterly hopeless. A poor risk may survive two or more operations when one radical procedure might prove fatal. The object of treatment is to cure the cancer or prolong life for a maximum period with a minimum of disability and discomfort. The patient must be made to realize the dangers of surgery, that death without it is inevitable, and that his coöperation is essential for recovery. He should be told that he has cancer, or that his tumor will become cancer if not removed.

Cure of cancer of the rectum involves many factors. Cancer cells are carried to adjacent tissues by direct contact, and to remote areas by lymphatics and veins, and the most radical removal of the growth with the structures which transmit these cells is essential, even though it entails complex changes in the anatomy and physiology of the individual.

At the present time it is the consensus that the combined abdominoperineal resection of the rectum and rectosigmoid offers the best chance of cure in the majority of cases. The one-stage procedure, as advocated by Sir Ernest Miles,<sup>1</sup> of London, is the method of choice in good risks. Next best, for those who are undernourished by starvation, those in whom medical decompression of an obstructed colon has not been successful is a cecostomy, or a colostomy followed in a short time by the combined abdominoperineal resection. One method has been suggested by Doctor Frank H. Lahey,<sup>2</sup> of Boston. In these so-called two-stage procedures the tumor remains in situ. The late Doctor J. B. Coffey,<sup>3</sup> of Portland, Oregon, described a two-stage procedure in which the tumor was displaced from its original bed and placed in the hollow of the sacrum beneath the new peritoneal floor, the perineal stage being performed later. The late Doctor Dudley Smith,<sup>4</sup> of San Francisco, modified the Coffey operation by the substitution of perineal for the abdominal drainage. A third method, the Colostomy and Posterior Resection, described by Sir Robert Lockhart-Mummery,<sup>5</sup> of London, is suitable in low growths in those who are poor risks because of cardio-circulatory-renal impairment, or in the aged in whom the expectancy of life is limited.

In selecting the radical procedure all the factors which have been obtained by physical and clinical tests are correlated. If the tumor is well fixed and there is definite signs of obstruction with marked malnutrition or other pathological processes, such as history of heart disease, cerebral accident, etc., the two-stage abdominoperineal or the colostomy perineal resection is considered safer than the one-stage procedure. In reviewing these cases no doubt many of the two-stage procedures would have resulted favorably if the one-stage had been carried out. Also, there is no doubt that if some of the one-stage, which terminated fatally, had been done in two-stages

the results would have been better. The two-stage procedure has been selected in the older patient who had lost considerable weight and suffered from malnutrition. There is probably little danger of the cancer spreading in that length of time, because it has, as a rule, been present from six months to two years. There may be some slight advantage, in that the inflammatory reaction will subside, but this should not be considered a logical reason to adopt the two-stage method. In the colostomy and posterior resection there are several inches of bowel left, and the amount of node bearing tissue removed does not equal that of the abdominoperineal method. Local reappearance occurs most frequently in low tumors.

The fourth curative, and also a preventive procedure, is the destruction of all adenomas, polyps, and papillomas by cauterization or desiccation. Removal of all pathological lesions is essential in the preventive program.

Other methods of treatment, as local excision, colostomy and perineal excision, cauterization, fulguration, and irradiation, should be considered as palliative and not curative.

#### REPORT ON CASES—AUTHOR'S SERIES

In the palliative series which total 199 there were 142 colostomies. Some of these were done as a preliminary to resection which was not carried out because the patient's condition did not improve. The colostomy does nothing more than relieve obstruction, and rarely decreases tenesmus and frequent desire to stool, especially in a low lying tumor. The colostomy and perineal excisions were done in those cases having large metastasis in the liver.

Epithelioma of the anus, sometimes called epidermoid, squamous or skin cancer, is comparatively infrequent, less than 5 per cent, is highly malignant in 75 per cent of cases, and metastasizes rapidly. Surgery and irradiation, used separately, have not proved successful, and it is the opinion of the writer that a combination of the two methods will give the best results. Metastasis, unfortunately, frequently occur before the diagnosis is made.

In a total of 862 cancer of the rectum examined by the writer there were 759 adenocarcinomas, 42 anal epitheliomas and 61 malignant adenomas, or polyps. The majority of these lesions were graded microscopically. In the adenocarcinomas 17 per cent were of low, 41 per cent moderate and 42 per cent of high degree. In anal epitheliomas 5 per cent were of low, 30 per cent moderate, and 65 per cent of high degree. Of the malignant adenomas, or polyps, 75 per cent were of low, 20 per cent moderate and 5 per cent of high degree.

The combined abdominoperineal resection in one-stage was performed in 90, the two-stage in 60, and the colostomy and perineal resection in 46 cases, with a hospital mortality of 11 per cent, 14.6 per cent and 13 per cent respectively. The majority of these deaths occurred during the first six years from causes which have been almost eliminated in the past five years. Continuous spinal anesthesia has been used in approximately 55 procedures and has been a factor in the decrease of the number of cases suffering from shock.

The mortality rate for the three groups dropped to 4.4 per cent in the next five and one-quarter years. During this period 73 consecutive abdominoperineal resections were performed with one death, which was due to coronary thrombosis, and sixteen colostomy and perineal resections with no deaths.

Death was attributed to shock in 11, hemorrhage in 6, peritonitis in 2, paralytic ileus in 2, pneumonia in 2, heart complication in 3, and intestinal obstruction in one instance. All patients dying during the hospital stay without other definite findings were attributed to immediate and delayed shock. Some of these deaths may have been



prevented if repeated transfusions had been given. Peritonitis was caused in one instance by erosion of the bowel by a catheter which had been placed into it for decompression. One patient with a small cirrhotic liver died within twelve hours from pulmonary edema and the autopsy revealed 1,000 cc. of blood in the stomach. This patient should have been operated upon in two stages. Two of the postoperative hemorrhage patients might have been saved if the intern had been properly instructed in the control of the bleeding. The two deaths occurring from pneumonia were prior to the common use of the sulfa drugs. Five deaths occurred in patients with metastasis. One patient died following a one-stage procedure for a large villous papilloma which might have been cured by fulguration.

In the series of 196 so-called curative procedures there were 11 cases which had definite metastasis to the liver. There were 19 cases which had metastasized to regional lymph nodes.

Forty-six cases of Grade I and II adenomas, polyps and villous papillomas have been treated with the cautery, or by fulguration, with no known recurrence. A modification of the Coffey two-stage method was performed ten times, preceded by a cecostomy or colostomy in six instances which made three stages. There was one death, one known recurrence, and one metastasis to the abdominal wall. One of the radical procedures has been performed in those cases with moderate metastasis to the liver. The tumor should be removed for the mental and physical comfort of the patient.

Five year survivals of private patients were 36 per cent in the one-stage, 25 per cent in the two-stage and 45 per cent in the colostomy and posterior resection procedure respectively. Local or pelvic reappearance occurred ten times in the abdominoperineal and once in the colostomy and perineal resections. All deaths from metastasis occurred within three years, except two, which occurred in the fourth year.

In the group of private patients, about 80 per cent of those explored were considered operable as far as removal of tumor was concerned. Some of those who were operable were not curable because of metastasis. There was no estimate of the operability of the private cases who went elsewhere for treatment. In the clinic cases operability was 68 per cent of those explored, and less than 50 per cent of the total number of admissions.

In the non-fatal complications, obstruction of the small intestine occurred eight times, being relieved in two cases by the Miller Abbott tube and in six by operation. Severe hiccoughs occurred three times, one of which required crushing of the phrenic nerve for relief. Thrombophlebitis occurred four times, with one pulmonary embolus. The saphenous vein was ligated in one case. The atonic bladder is to be expected in all cases, with recovery in the female being more rapid than in the male. Indwelling catheter drainage is routine for several days. Paralytic ileus, temporary or prolonged, is to be expected. This complication has been less frequent since a special colostomy clamp has been in use through which a large mushroom catheter is placed into the bowel allowing for immediate decompression of the intestine.

Success in any of these procedures depends upon the preoperative and postoperative care. During several days hospital stay, the bowel is decompressed medically, if possible. The diet is high in protein and carbohydrates. Vitamins, especially B and C, are given in large doses. Secondary anemia is improved by blood transfusion. X-ray of the chest is routine. Cystoscopy of the bladder is indicated when the mass is near the prostate or bladder. Kidney function is determined, especially the NPN estimation.

Postoperatively, the blood pressure is taken every 1

and 2 hours, and is kept near the patient's normal by necessary stimulants, intravenous fluid and blood transfusions. Whole blood is the most valuable agent to combat immediate and delayed shock. Water is taken as tolerated. The patient is turned every 1 or 2 hours, and encouraged to breathe deeply. A trapeze is a valuable aid. Water is increased on the first postoperative day, and tea, if desired. Chewing gum is valuable to keep the mouth moist and stimulate peristalsis. The catheter, in the bowel, is kept open by the instillation of air or water, and a Harris flush may be attached with perfect safety on the first postoperative day. On the second postoperative day broth, tea and toast are given and the patient encouraged to chew steak or beef. A non-residue diet is ordered if there are no contraindications, such as nausea, vomiting, or distention, on the third postoperative day, and the clamp and tube removed from the bowel. General diet is ordered after the first bowel movement. The patient exercises the legs and body frequently and takes 3,000 to 4,000 cc. fluid daily. He may sit up in bed in six or seven days, and out in a chair eight or ten days, and leave the hospital in fourteen days, to sixteen days.

There is still too much prejudice by the patient and by physician regarding abdominal colostomy. To this time, the writer has not been impressed with an artificial anus located in the perineum. It seems that the hygiene of the abdominal anus is more simple. A colostomy, properly prepared and watched to see that it does not become stenosed, may be easily cared for by the patient. In some instances the bowel movements assume a degree of regularity. In those individuals in whom strict hygiene is necessary, as physicians, dentists, nurses, and people who meet the public, the bowel may be kept quite clean by irrigations every other day. A colostomy bag made of rubber, is objectionable because of the odor. The male athletic support has been found to be the best type of girdle for these patients.

#### SUMMARY

The results obtained by radical surgical procedures for cure of cancer of the rectum have been presented. The combined abdominoperineal resection is the method of choice, and the one-stage is preferred, although a previous colostomy is of great value in certain cases. The colostomy and perineal resection is a method which may be used to advantage when others may not be suitable. A marked improvement in mortality and morbidity has been obtained. The cure of cancer depends upon (1) the education of the layman to recognize abnormal body function, and to seek competent medical advice at frequent intervals; (2) a thorough examination by his physician, (3) and the surgical treatment indicated in each individual case.

1930 Wilshire Boulevard.

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I tell you, fellow citizens, that the war was won by the American spirit. . . . You know what one of our American wits said, that it took only half as long to train an American army as any other, because you had only to train them to go one way.

—Woodrow Wilson, *Speech*, Kansas City, Mo.

SURVEY OF OVER 13,000 FRACTURES\*

IN THE EMPLOYEES OF THE RICHMOND SHIPYARDS

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THE 248,000 new cases seen by the Permanente Hospitals in Richmond and Oakland in the last two and one-half years included 13,261 fractures.

The value of a survey of this kind lies in presenting the general distribution of fractures occurring in the workmen of a heavy industry (shipbuilding) both on and off the job and of the general impressions regarding the treatment of fractures thus encountered. The medical care provided for the workmen in the Richmond shipyards included not only all industrial injuries occurring on the job but, in addition, those injuries and illnesses occurring off the job. Since approximately 90 per cent of the workmen belong to this additional voluntary health plan, the fracture experience presented in this report very closely represents the actual incidence of fractures occurring in the entire shipyard population (sixty to ninety thousand) during this two and one-half year period.

The figures as given represent individual fractures where they presented individual problems of treatment even though many patients sustained multiple injuries in a single accident. Except in the cases of metacarpal, metatarsal, phalangeal and rib fractures, they are enumerated individually.

TABLE 1.—Regional Classification of 13 261 Fractures

Name	Number of Fractures	Per Cent Incidence
Skull .....	193	1.5
Maxilla, Zygoma, Nasal.....	421	3.2
Mandible .....	117	0.9
Vertebrae—Cervical, Dorsal, Lumbar	320	2.4
Sacrum, Coccyx .....	70	0.5
Scapula .. .....	61	0.5
Clavicle .....	146	1.1
Sternum, Ribs .....	759	5.7
Pelvis .....	106	0.8
Humerus—head, neck .....	127	1.0
shaft .....	38	0.3
supra-condylar, condylar .....	69	0.5
Radius—head, neck .....	134	1.0
shaft (alone) .....	67	0.5
Radius and Ulna shafts (together) ..	80	0.6
Radius—distal end, including ulnar		
stylid .....	491	3.7
Ulna—styloid, head (alone).....	58	0.4
Ulna—olecranon, coronoid .....	84	0.6
Ulna—shaft (alone) .....	56	0.4
Navicular and Carpals.....	237	1.8
Metacarpals and Phalanges.....	4,263	32.1
Femur—head, neck .....	24	0.2
trochanter .....	20	0.1
shaft .....	39	0.3
supra-condylar, condylar .....	34	0.3
Patella .....	138	1.0
Tibia—condylar, tuberosity .....	102	0.8
shaft (including Fibula).....	324	2.4
Fibula—head, neck & shaft (alone) ..	200	1.5
Tibia—malleolus, epiphysis (alone) ..	180	1.4
Fibula—malleolus (alone).....	198	1.5
Tibia—malleolus, epiphysis and		
Fibula—malleolus (together).....	128	1.0
Tarsals .....	273	2.1
Metatarsals and Phalanges.....	3,704	27.9
Total Fractures .....	13,261	

SKULL

Although the 193 skull fractures were of primary interest to the Surgical Department they are included here for completeness of fracture statistics. The care for patients with skull fractures is primarily that of the associated head injury. Linear fractures of the skull require no special treatment for the bone injury. Fractures which are depressed for a distance equal to the width of the cortex are usually elevated. All compounded fractures are debrided and elevated if depressed.

FACE

Facial fractures involving the maxilla, zygoma and nasal bones numbered 421. These were of primary interest to the otorhinolaryngologist. The elevation of a depressed zygomatic arch is usually very satisfactorily attained by direct elevation or by use of a periosteal elevator slipped through a temporal incision downward beneath the temporal fascia to the under side of the zygoma. It is essential that the presence of a depressed zygoma be recognized immediately following injury because its presence may later be obscured by swelling of the face and the satisfactory result following early elevation be sacrificed. Complications such as diplopia and ectropia emphasize the importance of adequate care of these fractures.

MANDIBLE

Fractures of the mandible (117) were treated jointly by the otorhinolaryngologist and the orthopedist. The use of external pin fixation methods have proved valuable in many instances of multiple fractures of the jaw and in edentulous cases. The majority of mandible fractures however, are satisfactorily treated with interdental wiring.

VERTEBRAE

Fractures of the vertebral column (320) have followed the usual distribution of these fractures. We feel that an initial rest period of three to seven days before reduction eliminates the complications of abdominal distension and general discomfort of the patient, as well as affording added opportunity of observing the patient for associated injuries. As a general rule, no attempt is made during this period to obtain a reduction of the fracture. Reduction is then carried out under spinal anesthesia in the cases of lower segment fractures. For the most part we have allowed the patient to become ambulatory in a body cast during the second week of convalescence although at the present time we feel that many fractures, particularly those involving any lateral wedging or fractures involving the articular facets require a much longer period of bed rest. Physiotherapy and muscle re-education are extremely important, during the later stages of healing. We have not been able to influence the wedging of the thoracic vertebral bodies above the tenth thoracic segment. Patients with fractures in this area are treated by cast and bed rest with muscle strengthening exercises for six to eight weeks and then are allowed to be ambulatory in the cast.

Sacral and coccygeal fractures numbered 70. We have not needed to resort to removal of the coccyx in any case. In general, the results of actual fractures of the sacrum and coccyx have given less difficulty and better results than the contusions to this area without fracture.

Clavicle fractures numbered 146. Satisfactory results have been obtained by use of the figure of eight bandage, the T cross or the Roger Anderson type clavicle splint. We have had one nonunion, this in the distal end of the clavicle with acromio-clavicular and coroco-clavicular ligament tears.

\* Read before the Section on Industrial Medicine and Surgery at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.  
From the Permanente Foundation Hospitals.



## STERNUM AND RIBS

Fractures of the sternum and ribs numbered 759. Extensive fractures of the ribs involving the majority of ribs on one or both sides of the chest still present a very grave problem of management. The respiratory embarrassment which accompanies these injuries, complicated by paradoxical respiration, tension pneumothoraces and hemothoraces require constant supervision. Towel clip or wire traction to the ribs definitely gives some aid in decreasing mediastinal shifting. It is felt that the iron lung has definite value in some instances. As a general rule aspiration of a hemothorax is not carried out except for definite respiratory embarrassment. Decompression of a tension pneumothorax is of utmost importance. Areas of atelectasis and pneumonia following even trivial chest injuries are recognized, and strapping and limitation of motion of the ribs is discouraged. Whenever possible the pain associated with fractures of the ribs is controlled with intercostal nerve injections, hypodermic infiltration of novocaine or ethyl chloride spray.

## PELVIS

Fractures of the pelvis (106) fall into two definite groups: those involving fractures of the weight bearing lines, that is, of the main arches, and those involving the secondary or tie arches alone. The majority of fractures of the latter group tend to override rather than distract and in the majority of cases treatment with a pelvic sling is not necessary. Fractures involving a separation of the symphysis pubis are of course treated with a pelvic sling.

The most serious fractures of the pelvis are those extending through or near the sacro-iliac joints. The double vertical fracture of the type described by Malgaigne requires traction over a prolonged period of time and displacement frequently recurs after eight weeks. The Watson Jones method of reduction and application of a spica cast has been used in several cases without satisfaction. The casts had to be removed because the reduction could not be maintained and because of the discomfort of the patient.

Lumbar plexus nerve injuries have been associated with several cases of sacral fractures and in general have had incomplete recovery.

## HUMERUS

Fractures of the head, neck and shaft (165) have been, for the most part, very satisfactorily reduced and treated by use of hanging casts. An attempt is made to reduce the fracture in order to insure bony apposition. It is desirable to maintain slight abduction of the lower fragment to insure maintenance of the carrying angle. Early exercises of the shoulder joint are important and are usually begun in seven days.

Supracondylar fractures of the humerus are frequently comminuted and traction thereon is necessary. A downward pull on the proximal fragment, of the Dunlop variety, or Kirschner wire traction through the olecranon are of great value.

## RADIUS

There were 134 fractures of the head and neck of the radius. Impacted fractures of the head may be treated conservatively with early mobilization. In non-impacted fractures of the head, open operation is indicated. Where less than two-thirds of the head remains intact, excision of the head has given satisfactory results. Shaft fractures of the radius alone were in most cases successfully treated by closed methods. If the fracture line is oblique it may require traction or open reduction to prevent shortening and consequent inferior radio-ulnar dislocation.

Fractures of the distal radius (491) were in general satisfactorily handled by closed manipulation. It has

frequently been found advisable to extend the cast above the elbow. Comminuted fractures frequently require traction in order to prevent shortening. Operative methods are rarely used.

## ULNA

There were 84 fractures of the olecranon and coronoid. Olecranon fractures with displacement are always opened. Coronoid fractures almost never require manipulation or open treatment. Fractures of the shaft of the ulna alone were usually no problem; nor were those of the ulnar head.

## RADIUS AND ULNA

Fractures of both bones of the forearm with displacement may present a difficult problem. First attempt was always made at closed reduction. Even though first reduction seemed satisfactory, frequent x-rays are necessary during the first few weeks to detect any tendency toward loss of alignment. Open reductions were frequently necessary in this group.

## CARPALS

Two hundred and thirty-seven carpal fractures were encountered. Navicular fractures require long immobilization, but in our experience fresh fractures have usually united if given sufficient time.

Next to the most frequent carpal fracture seen is the triquetrum. A minute fragment may be the only visible evidence of injury. The wrist may be painful for three to six months. Transcarpal dislocation with fracture of the navicular must not be overlooked. If early closed reduction is possible the results are usually good.

## METACARPALS AND PHALANGES

There were 4263 fractures of the metacarpals and phalanges. We have been very much impressed with the seriousness of fractures of the metacarpals and phalanges in the relationship to tendon adhesions and resulting disability. Skeletal traction with either a pulp pin or fine Kirschner wire transfixing a phalanx has been utilized in almost all cases of oblique or spiral fractures of the metacarpals.

## FEMUR

There were 24 fractures of the head and neck of the femur. Displaced neck fractures are nailed in the customary manner, particular care being taken to obtain a valgus position. Impacted ones have in most cases given excellent results with conservative treatment consisting of light traction.

Several of the twenty trochanteric fractures have been fixed with a Neufeld angle nail with a view to early mobilization. These have given very good results.

Shaft fractures (39) have been treated most successfully with skeletal traction of sufficient duration. This has not infrequently been combined with manipulation in traction. In the few cases where external pin fixation of the Roger Anderson type has been tried, results were unsatisfactory and we usually returned to traction or cast.

Supracondylar fractures also do well in traction. Angulation of the distal fragment may be very difficult to correct. This type of fracture has not infrequently resulted in limitation of extension of the knee.

## PATELLA

Of the 138 patellar fractures, the majority showed displacement and many were severely comminuted. Undisplaced fractures showed excellent recovery when early mobilization was carried out at the end of four to six weeks. Where the lower pole was badly comminuted, the

lower comminuted portion has been excised and the patellar tendon sutured to the proximal fragment with strong stainless steel wire. Even in these cases, early mobilization is the rule. Complete patellectomy is reserved for the extremely comminuted patella where prospect of restoring a smooth articular surface is poor. There have been three cases of post-traumatic osteochondritis of the patella following fracture by direct trauma.

#### TIBIA

Condylar fractures (102) have been mostly of the depressed type. Where the depression is not too marked, we have found excellent functional results following conservative treatment with early mobilization and late weight bearing. The occasional case has required surgical elevation of the depressed condyle with bone chips from the wing of the ilium to maintain position. The depression has usually been central; occasionally posterior.

There were 324 fractures of the tibia, many of them compounded. In general, we have found that oblique and comminuted fractures of the tibia and fibula are best treated in the following manner: A Kirschner wire is placed through the os calcis and a traction bow applied. Under anesthesia the knee is brought to the edge of the table so that the leg hangs freely. Traction may then be applied by the surgeon with his foot by tying a sling through the traction bow, thus leaving the hands free to manipulate the leg. When alignment seems satisfactory, a short leg plaster is applied and allowed to set. The cast is then extended above the knee, using about thirty-five degrees of knee flexion to control rotation. The patient is placed in bed in traction with slings to support the cast. The cast may be wedged if necessary without disturbing traction. We believe the cast should be changed as infrequently as possible. Traction is maintained as long as necessary, usually six to eight weeks.

In spiral fractures of the tibia, early weight bearing and excellent position were afforded when open reduction was performed and the fracture fixed with a Mathewson sling of heavy stainless steel wire. Where the fibula remains intact, it is occasionally necessary to osteotomize it in order to secure good contact of the tibial fragments.

We have found multiple pin fixation methods undesirable in these fractures because of the reaction about the pinholes. Even where the process remains aseptic, the chronic low grade inflammatory reaction produced causes a lymphadema with fibrosis which results in limitation of function.

Fractures of the malleolus and epiphysis were 273 in number. Many of these were with minimal displacement and were easily cared for with good results. In displaced bimalleolar and trimalleolar fractures we have found an increasing tendency toward internal fixation of one or both malleoli in cases where closed manipulation has not given good anatomical reposition. This also allows earlier mobilization.

#### TARSALS

Fractures of the os calcis comprised the majority of the 273 fractures of the tarsal bones.

A wide variety of methods have been used in the treatment of os calcis fractures. The Böhler technique results in a good reduction if the fracture is not extensively comminuted, as does a multiple pin procedure. The latter allows freedom of ankle motion during healing of the fracture. Equivalent results are usually obtainable however, by simple compression to correct the widening deformity and casting. Triple arthrodeses have been done in approximately 10 per cent of the os calcis fractures.

#### METATARSALS AND PHALANGES

Metatarsal and phalangeal fractures numbered 3,704. Here, as in metacarpal and phalangeal fractures, skeletal traction may be necessary in oblique, spiral or comminuted fractures. Immediate weight bearing is the rule, either with a felt arch support or a walking cast.

In general, we have been impressed with the advantages of immediate treatment of all fractures, of complete and careful debridement of all compound fractures, and with the prophylactic use of systemic and local sulfonamides and especially the prophylactic use of penicillin. We have not hesitated to use wire or plating if necessary to maintain the proper position of fragments in compound fractures.

#### SUMMARY

The fractures experienced by approximately sixty thousand people over a period of two and one-half years totaled 13,261. These fractures are briefly classified and described.

Broadway and MacArthur Boulevard, West.

### CARDIAC PATHOLOGY AS RELATED TO ANESTHESIA\*

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**D**URING recent years, the importance of the preoperative examination of the prospective surgical patient has been recognized universally. The completeness of that examination will necessarily depend upon the urgency and seriousness of the operation, the availability of the patient before operation, and the general physical condition of the patient. During this preoperative examination, whether by surgeon, consulting internist, or anesthesiologist, the cardiovascular system is under close scrutiny.

Marvin<sup>1</sup> has pointed out that the "most helpful evidence we can obtain regarding the heart's functional condition is the record of its response to what might properly be termed the stress and strain of daily life:—the walking, the running, the stair climbing, the periods of emotional excitement, the innumerable mental and physical activities in which we daily indulge." If the history reveals breathlessness on exertion, orthopnea requiring the use of two to three pillows, cough and ankle edema, physical examination takes on an increased importance. Such an examination then should include a determination not only of blood pressure, pulse, and cardiac thrills, murmurs, rate and rhythm, but also of venous distension, cyanosis, location of apex beat, basal rales, pleural effusion, liver enlargement, ascites and ankle edema. In addition to the routine urinalysis and blood counts, special examinations may properly include sedimentation rate, circulation time, venous pressure, electrocardiograms, and fluoroscopy.

#### WHEN MILD CONGESTIVE FAILURE IS PRESENT

If such an examination shows the pressure of mild to moderate congestive failure, operation should be delayed, if possible, and adequate preoperative cardiac treatment instituted. If no previous digitalis has been administered,

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rapid digitalization may be accomplished orally, using digitalis purpurea. The digitalizing dose usually corresponds roughly to one cat unit for each ten pounds of body weight of the patient. Lantoside preparations, i.e., Burroughs-Wellcome's Digoxin and Sandoz' Cedilanid, which are glucosides derived from leaves of digitalis lanata, give more rapid oral digitalization. These glucosides are absorbed three times as readily as oral digitalis purpurea. The average oral digitalizing dose of Cedilanid is 7.5 mg. given over a three day period. Following restoration of the patient's cardiac compensation, it is preferable to allow him up and around for two to three weeks or longer prior to operation, if time permits, rather than immediately submitting him to surgery and anesthesia after a long period of bed rest and inactivity. Then at the time of operation every effort should be made towards shielding him from any emotional turmoil and the operation should be as brief and free from hemorrhage and trauma as possible. Oxygen should be administered generously to insure against anoxemia. During the operation the position of the patient should be such as to insure his comfort and to avoid excessive pressure against his chest by drapes, equipment, and the weight of a surgeon's or nurse's arm.

#### WHEN IMMEDIATE SURGERY IS INDICATED

Given a patient with moderate to severe congestive heart failure and in need of immediate surgery, the preoperative preparation should be instituted as soon as possible. During this preparation, oxygen by mask, catheter, or tent should be administered continuously to insure adequate oxygen supply to the myocardium. Phlebotomy should be done, drawing off 400 to 700 ccm. of blood, the amount depending upon the severity of the patient's decompensation and his red blood cell and hemoglobin level. This blood, collected into a sterile bottle containing the proper preservative and stored at 4° C., later may be given back to the patient during operation if needed. Following the phlebotomy, digitalization may be rapidly obtained by the intravenous injection of 8 ccm. (1.6 mgm.) of Cedilanid. This then may be followed by the average daily oral maintenance dose of 0.5 to 1.6 mgm. of Cedilanid. The administration intravenously of a mercurial diuretic, such as salyrgan or mercupurin, and perhaps 25 to 50 ccm. of 50 per cent dextrose may be advisable. Also any appreciable pleural effusion or ascites should be aspirated prior to the surgical procedure. By these methods or a combination of them, a severe congestive failure case may be converted into a better risk for the prospective anesthetic and operative procedure.

#### GENERAL REACTIONS OF CARDIAC PATIENTS TO ANESTHESIA

Patients with heart disease of practically all types (congestive, rheumatic, hypertensive, coronary, thyrotoxic) withstand anesthesia and surgical operation amazingly well, even with auricular fibrillation, slight angina pectoris or mild congestive failure, if care is observed. However, marked congestive failure, recent coronary thrombosis, severe angina pectoris, complete heart block, and syphilitic heart disease with aortic insufficiency, all of which notoriously are apt to lead to sudden death even with the patient at complete rest, add considerably to the operative risk.<sup>2,3</sup> In such cases elective surgical procedures should be avoided.

#### RHEUMATIC FEVER

The anesthetist on occasion may be confronted by a patient who is sick with acute rheumatic fever, and yet needing emergency surgery. This was particularly true during 1941-1942 when there were outbreaks of rheumatic fever in epidemic proportions among Army and Navy personnel throughout the country. In evaluating one of these patients preoperatively, it is particularly important not only to check him for symptoms and signs

of cardiac decompensation, but also for pericardial effusion and any pulmonary or pleural involvement. When found, the effusion fluid should be aspirated prior to any emergency anesthetic and surgical procedure. In three personally observed acute rheumatic fever patients, definite pneumonitis with marked pleural effusion was a complication.

An important type of heart disease, not uncommonly met by the anesthesiologist, is so-called "thyrotoxic heart disease," occurring in the 20 to 40 year age group. Here the heart and circulation is simply physiologically overactive as a result of the thyrotoxicosis, and auricular fibrillation, cardiac enlargement and congestive heart failure have developed. The standard preoperative administration of 5 grains of potassium iodide or 5 drops of Lugol's solution three times daily for a week usually slows the heart rate. Auricular fibrillation, common in thyrocardiacs, is not a contraindication to general anesthesia or surgical operation, but if there is time, it is wise to attempt first to control the arrhythmia by the administration of quinidine or digitalis. Often it will be difficult or impossible to control the auricular fibrillation until the thyrotoxicosis is corrected by operation.

During the years since 1912 when Herrick<sup>4</sup> first described the "Clinical Features of Sudden Obstruction of the Coronary Arteries," cases of myocardial infarction have been recognized more and more frequently. In the Army it has been amazing to see a large number of coronary accidents in patients 20 to 45 years of age. Elective surgical procedures should be avoided on such patients until two to three months after their sedimentation rate returns to normal, their electrocardiograms have become stabilized, and the patient is out of bed and about his daily activities.<sup>2</sup>

Hypertensive heart disease is the most common and important of all types of cardiovascular disease and has as its consequences, heart failure, cerebral hemorrhage or thrombosis, coronary heart disease, and renal insufficiency. Coarctation of the aorta, a fairly common congenital abnormality, may give rise to a definite hypertension in the brachial arteries. From the anesthesiologists' standpoint, patients with arterial hypertension are definite risks, since frequently a dangerous fall in blood pressure may follow the administration of a spinal anesthetic, and cerebral or coronary accidents may occur during a rough excitement stage in the course of induction with inhalation anesthesia.

Cardiac arrhythmias may cause the anesthesiologist concern. One of the commonest arrhythmias encountered in daily life is the simple premature systole, usually of ventricular origin. Such arrhythmias occur at some time during the life of practically all persons and usually is of little importance. In susceptible individuals the occurrence of premature systoles may be precipitated by mental and physical fatigue, and by excesses of tobacco, tea, coffee, and alcohol. The appearance of frequent ventricular premature systoles following an acute myocardial infarction is considered by some cardiologists to be an indication for the immediate administration of quinidine in an effort to prevent possible ventricular fibrillation.

Chloroform and cyclopropane may produce premature systoles, paroxysmal tachycardia, and in experimental animals, ventricular fibrillation and death. The sudden death of patients during anesthesia with these two agents is thought to have occurred through this mechanism. For this reason both White<sup>3</sup> and Adriani<sup>5</sup> recommend that chloroform and cyclopropane never be administered when the heart is already irritable or diseased. This theoretical objection is a contraversial one and each case must be decided on its own merits.

The matter of arrhythmias in relation to cyclopropane

anesthesia has been submitted to extensive study by various investigators.<sup>6,7,8</sup> It has been demonstrated experimentally in dogs that during cyclopropane anesthesia the simultaneous administration of epinephrine or related amines further increases cardiac irritability and gives rise to more pronounced arrhythmias. In dogs, such a combination may produce ventricular fibrillation. A similar combination in man may be equally dangerous and should be avoided. A number of drugs, including barbiturates, procaine morphine, atropine, and quinidine, have been utilized without consistent success in the prophylaxis and treatment of these arrhythmias during cyclopropane anesthesia.<sup>9,10,11</sup>

Even during routine anesthesia with ether, premature systoles, paroxysmal tachycardia, and disturbances of the sinoauricular pacemaker are not uncommon. Usually they are of little importance, but the rapid pulse of paroxysmal tachycardia may cause alarm. Generally, the tachycardia subsides spontaneously, although it may require carotid sinus pressure. If that is unsuccessful, the intravenous administration of Cedilanid or quinidine may be advisable, although it is doubtful if this would be necessary during the average operation.

#### ON CHOICE OF ANESTHETIC AND METHOD OF ANESTHESIA

In the choice of an anesthetic agent and method of anesthesia for patients with cardiovascular disease, there is some variance of opinion. Despite the above mentioned abnormalities of cardiac rhythm which are common under anesthesia during operation, it must be remembered that anesthetics do not cause heart disease. In view of the frequent occurrence of a variety of arrhythmias during cyclopropane anesthesia, even in the presence of adequate oxygenation, Adriani<sup>1</sup> recommends that one err on the side of conservatism and omit cyclopropane when choosing an anesthetic for patients with definite cardiovascular disease. He is of the opinion that "ether, from the standpoint of effects on the heart muscle itself, is the best of the available anesthetic agents in cardiac disease." Ethylene apparently is a very satisfactory anesthetic from the cardiac standpoint and is preferred by Marvin<sup>1</sup> and White.<sup>3</sup> Lahey<sup>12</sup> likewise prefers the ethylene-oxygen combination for thyroidectomy in thyrocardiac cases.

Circulatory collapse during spinal anesthesia occurs more frequently in subjects with cardiovascular diseases, such as hypertension or arteriosclerosis. Thus it seems wise to avoid spinal anesthesia, particularly "high spinals," i.e., above the 5 to 6 thoracic segments, in patients with cardiovascular diseases. If spinal anesthesia appears advisable for such a patient, closely supervised support by oxygen inhalation, ephedrine, and intravenous fluids will usually obviate the possible circulatory collapse.<sup>13</sup>

The advisability of using regional or "block" and local infiltration anesthesia will depend not only upon the skill and dexterity of the anesthesiologist, but also upon the emotional make-up of the patient. Regional anesthesia given by a skillful anesthetist to a calm individual is the ideal from the cardiovascular viewpoint.

Altogether, the problem of an ideal anesthetic for cardiovascular cases is controversial. One of the prime factors in deciding upon an anesthetic procedure for a given case will be the anesthesiologist's experience with a given method, thus avoiding undue emotional trauma to the patient in regional anesthesia and insuring a smooth induction and maintenance during general anesthesia.

Collapse or death during anesthesia and surgical operations is rarely due to heart disease, almost invariably being due to hemorrhage, trauma, anoxemia, or shock. Treatment of such collapse should be directed towards avoiding these causes.

The rare case of cardiac arrest should be treated by: 1. artificial respiration by means of rhythmic pressure on the rebreathing bag of a closed circuit with an endo-

tracheal tube in place, and 2. artificial circulation by means of rhythmic direct manual compression of the heart directly if the thorax is open, or indirect compression if the abdomen is open.<sup>11</sup> Otherwise, the thrusting of a needle through the right third intercostal space parasternally into the right auricle of the heart may initiate cardiac activity. Hyman<sup>15</sup> has demonstrated that such stimulation of the auricle by needle prick is preferable to that of the ventricle because following the latter maneuver in dogs ventricular fibrillation is common. He further demonstrated that the initiation of a systole by the prick of a needle is by itself more important than is the injection of any substance, such as adrenalin.

Postoperative cardiovascular complications may include paroxysmal tachycardia, paroxysmal auricular fibrillation, coronary thrombosis, and congestive heart failure.<sup>16</sup> More common postoperatively than a serious cardiac complication is the not uncommon complication of pulmonary embolism which may give rise to an acute cor pulmonale which may be confused with coronary thrombosis or acute pulmonary edema of cardiac origin. The occurrence of pulmonary embolism demands the immediate investigation of the lower extremities for venous thrombosis, by means of diodrast venogram if necessary, and ligation of the thrombosed vein if one is found.

#### IN CONCLUSION

In conclusion, it is to be emphasized that the problem of the ideal anesthetic for cardiovascular patients continues highly controversial and that at present it is probably more important to choose the anesthetic procedure which is best adapted to a given anesthesiologist's training and experience.

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## FILARIASIS\*

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*Oceanside*

WITH the exception of a very few medical schools the courses in tropical medicine have for many years consisted of a few lectures by instructors who reviewed many subjects with which they had had little or no experience. This situation was reasonable as tropical disease for most of us was a negligible problem and clinical teaching material was almost entirely lacking. Such diseases as filariasis were remembered from student days only for the vivid illustrations in medical texts showing a weebegone native of the South Seas with an elephantine arm or leg or a vastly more pitiful creature dismally enthroned on a massive scrotal tumor.

## I.

It was thus uninstructed that medical officers landed in the various islands in the Samoan Defense Area early in 1942. Within a few days all of us had seen dozens of otherwise healthy and happy Samoans obviously suffering from filariasis. Inquiring as to the likelihood that the white man might contract the disease we were comforted by the information that the United States had maintained a Naval Station at Pago Pago for over forty years and though the tour of duty was eighteen months the diagnosis had never been made in the case of Naval personnel and it had been no reason for concern.

Long before the war the Samoans had been well instructed in the principles of personal and public hygiene in government sponsored schools. The Medical Department of the Navy had conducted an excellent public health program, pure water sources had been provided and the proper facilities were provided for personal cleanliness. There is an excellent hospital for the care of acutely ill natives which includes a nurses' training school. Especially well qualified pharmacist mates were detailed to important localities to teach hygiene, treat minor ailments and to act as sanitary inspectors under the supervision of Naval medical officers. Under this system and with the experience of over forty years, contact with the natives was not considered as a source of acquired disease and filariasis though a constant problem in the medical care of the Samoans was the least of the personal concerns of Americans serving in that area.

When one considers why the symptoms of filariasis did not appear among Naval personnel at the station for so many years, in the light of what we now understand about the epidemiology of the disease, the reasons could possibly be as follows: (1) mosquito control about the living quarters was excellent, (2) the living area was wind swept, (3) there was little or no reason for the majority of Naval personnel to be present daily in highly endemic areas especially at dawn or dusk, (4) the life was relatively easy requiring the minimum of physical exertion, (5) if symptoms did appear they were of minor intensity and subsided in due time after return to the mainland.

\* \* \*

It was not more than a month or two after our arrival that we began to see a few Marines who had lived on the island for several months longer than we, complaining of swollen forearms, tender inguinal and axillary

glands. We searched diligently for hand and foot infections, insect bites or evidence of allergic phenomena. Inguinal glands were easily explained on the basis of the ever present fungus infection of the feet and adrenalin did seem to help some of the forearms. But no single medical officer had more than a few contacts with these cases and they were not discussed except in retrospect, much later. The idea that we were seeing early filariasis entered the minds of all of us but the burden of evidence was against the diagnosis and it was not until the cases began to appear in almost epidemic proportions that it was seriously considered. Unfortunately there were no facilities at the time to demonstrate the diagnosis.

The American fighting man is by nature so friendly that it is a miracle he fights as he does. In no time after arrival he became a daily visitor in the hospitable homes of the Samoans, was learning their language, traded with them for native handiwork, loafed comfortably in the cool shade of the primitive houses and in perfect confidence swatted their infected mosquitos, too often too late. The bites itched but little and persisted only a short time so mosquitos were not considered too great a pest.

Many of our camps were located near or even in the midst of native villages, living quarters frequently being buildings of native construction and for the reason that most of the militarily important points on the shore were already occupied by native villages and living in or near villages provided not only camouflage but were most accessible to roads, trails and water. In order that the limited armed forces might use all their skill in establishing and operating defensive installations, much of the manual labor was performed by native men who necessarily spent most of the daylight hours in close proximity with the Marines and Sea Bees. The natives, newly introduced to movies crowded to the outdoor performances, sitting with their new friends during the hour of dusk, the same mosquito population biting the same groups night after night. Thus for friendly as well as military reasons the mingling of Marines and natives was quite constant.

At night all men were protected by nets and supposedly safe from mosquitos and the diseases they transmit. The nocturnal net produced an illusion of security for it was not until later that it was realized that the local vector of filariasis was a day biter, most voracious at dawn and dusk. Relaxation in the cool of the evening among friendly natives and their not too vicious mosquitos was never considered as hazardous. It is now obvious that our men were bitten by infected mosquitos from the first days in the area.

After four months in Samoa, really not aware that filariasis was to be a problem, observations were continued in another group of islands four hundred miles from Samoa, a group not under American government, where hygiene and responsible medical supervision was for practical purposes unknown. The endemic diseases were filariasis, probably 80 per cent, leprosy 10 per cent, yaws, tuberculosis and gonorrhea were household diseases. The native food supply was extremely limited and the problem of day to day survival was more important than cleanliness or mosquito control. It has been stated that this island is one of the most highly endemic filarial areas in the world with the exception of central Africa. Among the natives a well developed three limbed case of elephantiasis, unless the man was an obvious idiot, was a badge of distinction and made him a likely elder statesman. If a man survived all the locally available pestilences to the age of fifty he had been so thoroughly reinfected with filariasis that the normal course of the disease provided a badge of survival and distinction.

And here as in Samoa our men lived in the jungle. The island was so small that every tree, bush and leaf

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was cherished as essential camouflage. To find a tent site the men cleared a sixteen by sixteen foot space in the bush and erected a sixteen by sixteen foot pyramidal tent, covering it with foliage if any part was exposed to the sky. To cut a palm tree, bush or other overhead cover without official permission could easily have been a court martial offense. The washing water, for lack of wells, was collected in tent flaps and drained into gasoline drums. They soon swarmed with mosquito larvae for there was no screening to cover them. The serious water shortage was reflected in the coconut shells that for years had carpeted the island, each one a rainwater container and hence mosquito breeder. Generations of water-starved natives had depended on coconut water for drinking when working in the palm and banana plantations. From childhood they learn to carry long knives all day with which to open the nuts for a drink, the shells were discarded and in them mosquitos bred. Other fallen nuts were opened by rats and crabs and became water containers. To ease the labor of tree climbing, notches had been cut in tree trunks and in the rot holes that developed other breeding spots were produced. In short, the requirements of survival had produced millions of water containers and mosquito breeders.

Here again for military reasons and for water supply our camps were established close to or in the midst of native villages where infected mosquitos were concentrated. Under the circumstances the best that could be done was accomplished, the military considerations being paramount and the medical problems imperfectly understood.

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As weeks passed an increasing number of men appeared at sick call complaining of swollen arms, legs and testicles. We soon felt sure we were seeing the early manifestations of filariasis. Eventually the symptoms and findings compelled us to evacuate patients to the base hospital in American Samoa for establishment of the correct diagnosis. In the meantime the Force Surgeon, Captain I. W. Jacobs (MC), U.S.N., appointed Captain J. G. Dickson (MC), U.S.N., Senior Medical Officer, U. S. Naval Station, Tutuila, to head a Filariasis Commission to study the problem. The Commission's preliminary report<sup>1</sup> was published in September, 1943, being followed by many excellent papers by other writers on various phases of the subject.

Manpower loss required action on our island. The epidemiological facts were presented to our commanding officer who accepted them for action. He felt that if the island was going to be attacked from the air it would be so thoroughly that camouflage would not make much difference. He felt that some protection could be sacrificed if it would conserve manpower. So an enthusiastic mosquito control program was approved which finally left every camp a miniature park. In addition to clearing breeding and resting places high priority screening was finally delivered and employed as far as it would go. The mosquito crop was sharply reduced but in that lonely island the men continued to seek the company of their native friends, and though the danger was explained and prohibitions set up, visiting continued. It was impossible to police the whole island when we were short of men to man the defenses. But in due time, after at least a third of the personnel were known to be infected, the war moved on, by far the most effective preventive measure employed. The men departed.

## II. EPIDEMIOLOGY OF FILARIASIS IN SAMOAN AREA

Throughout this experience much has been learned about the early manifestations of filariasis. The majority of the writers on the subject prior to this war studied the disease in native populations in the West Indies,<sup>2</sup> Poly-

nesia and Africa and for the most part their patients were those who had been reinfected for many years, in many cases to the point of marked elephantiasis. Little or nothing had been written on the disease by Europeans who comprised the largest numbers of foreign residents and at no time previously had so many thousands of young men from temperate climates been suddenly thrust into endemic areas and into living conditions so ideal for contracting the disease.

1 1 1

Of the six varieties of the disease classified as filariasis the one under discussion and the most common is known as Bancroftian filariasis known to be caused by the *Wuchereria bancrofti*. It is found in the tropics and subtropics between 24 N. and 24 S. latitude, is most concentrated in the Samoan islands, Fiji, the West Indies and central Africa.

The parasite,<sup>3</sup> a nematode, is a thread-like worm, the adult being 4 to 10 centimeters in length and its embryo, the microfilaria, is about 200 to 300 microns in length. Its habitat is in the lymphatic glands and larger lymphatic vessels of the abdomen, pelvis, extremities and genitalia, lying tightly coiled close to the underlying fascia. The microfilariae are discharged in large quantities from the uterus of the females into the blood stream unless lymphatic blockage prevents, the adult remaining in situ until its death. In natives who have been reinfected over many years and who supposedly have hundreds of females producing at all times, the microfilaria can be found in nearly every blood smear regardless of whether elephantiasis exists or not. In fact extensive lymphatic blockage may definitely reduce the number of microfilaria in the blood. In our minimally infected men<sup>4</sup> microfilariae are so rare that they have never been found and the one positive diagnostic finding has been denied us. The failure to demonstrate the microfilaria adds valuable evidence that the symptoms of filariasis are not due to the presence of microfilaria in the blood.

From natives who team with the organism, mosquitos may easily ingest them at any bite and one mosquito has been found to contain as many as thirty embryos.<sup>5</sup> The ideal mosquito host and most common in the Samoan area is *Aedes scutellaris* var. *psuedo scutellaris*, a dawn, day and dusk biter. The microfilaria develops into the larval stage in the thorax of the mosquito and after fourteen days reaches the head and proboscis from which it is deposited on the skin or enters the capillaries either through the puncture wound or a penetrating mechanism of its own. It is then entrapped in a lymphatic gland or lymph channel where in two or three months it reaches adulthood and after fertilization reproduces.

The mosquito breeds by preference near human habitation in shells, cans, rainbarrels, sagging canvas, fallen tree trunks, rot holes, boxes, bottles, metal fixtures, trailer or truck bodies or any place that can hold a few ounces of water for five to ten days. It is rare in ground puddles or swamps, is a day feeder especially in dense shade at dawn and dusk and will attack in strong daylight even in a breeze and rarely bites at night unless disturbed. It rests in grass, vines, underbrush, beneath houses near the ground and where protected from the light, usually close to its breeding and feeding area.<sup>5</sup>

Its flight range is short, a fact demonstrated by Byrd, St. Amant and Bromberg in their excellent study in the Samoan area,<sup>5</sup> where it was shown that the number of infected mosquitos captured at the periphery of a native village was remarkably small as compared to those found at the center of the same village. They showed that where in the center of a village mosquitos were 25 per cent infected, fifty yards from the center the infected rate drops to 4 per cent and at a hundred yards only an occasional mosquito will contain larvae. They also demon-



strated that persistent winds shift the center of concentrated infection to the lee side of the village even when it is jungle bound, such villages usually being inland, as the natives have long chosen the breezy shores on which to live, the lee shores being considered almost uninhabitable.

Byrd and his colleagues investigated the degree of infection among the natives and were easily able to demonstrate it to be present in from 20 to 50 per cent and there are reports as high as 80 to 90 per cent. The peak of demonstrable infection has been shown to be between the 20th and 40th years and that children under two years rarely have sufficient to be demonstrable.

The presence of such diseased natives in a Marine camp every day was shown to produce 13 per cent infected mosquitos. They were accustomed to walk through the camp twice daily to and from their work and when traffic was stopped the infected mosquitos dropped to 1 per cent.

These remarkably complete studies on the epidemiology of filariasis in the Samoan area were unpreventably too late to help the men already infected but they did result in certain conclusions that will be valuable when again large numbers of troops must live in a highly endemic area. They are as follows:

1. Breeding habits of the vector preclude effective eradication in jungle choked areas, being better accomplished in small camps where the breeding rate can be kept at the minimum.

2. Complete eradication of mosquitos can only be accomplished in the small atoll type of island in which the land mass and dense jungle growth present little or no problem.

3. Short flight range of the vector makes hyperendemic areas small and controllable in villages and camps

*Precautions are as follows:*

1. Troops and natives should not be quartered in the same area, at least 500 yards should separate them.

2. Where this is impossible camps should be to the windward of native dwellings.

3. Natives should be kept out of camps and essential workers among them should be checked by blood smear for infection.

4. Troops should be forbidden to enter native villages in the daytime, but if necessary they should be properly dressed and should use mosquito repellents.

5. Screened quarters, bed nets and mosquito control measures should be employed.

6. Breeding places, resting places such as grass, vines and bushes should be removed up to 100 yards from the camp.

*Tissue Reactions:*

Though biopsy of involved glands may show the adult parasite it is now known to be an unnecessary and possibly harmful procedure. Zukerman and Hibbard<sup>6</sup> have made an essential study of 62 lymph nodes removed from patients obviously suffering from filariasis. Their conclusions are as follows:

1. Infestation with *Wuchereria bancrofti* is accompanied by a generalized disturbance of the reticulo-endothelial system which manifests itself as a hyperplasia of these specialized cells.

2. The endothelium of the lymph channels is similarly affected and the end result is an obliterative endolymphangitis.

3. Local eosinophilia is due to the presence of the parasite, usually the result of a dying parasite.

4. There was no evidence of bacterial infection as a cause of the lymphangitis. Furthermore the failure of any response to sulphonamide therapy argues against any

cause except the worm or its toxic disintegration products.

5. The plugging of the lymphatic channels by the worm causes a backing up of toxic products centrifugally, which would account for the so-called retrograde lymphangitis.

From the clinical standpoint the lesions are of two kinds, a persistent nodular lesion surrounding an adult worm or its remains and a diffuse transient retrograde lymphangitis presumably a sensitization phenomenon due to a diffusible agent released from a worm which may be some distance from the lesion. The lymphangitis is non-bacterial with involvement of the extremities and genitals primarily. There may be in addition localized areas of itching skin or swellings of the forehead, encouraged by tight hat bands and probably allergic in origin.

The early symptoms which brought the patients to the attention of medical officers were swollen forearms, thighs, legs or scrotum with accompanying enlarged glands in the drainage area of the parts involved. Often with the swelling there would be the appearance or history of a wide red streak running down the inner aspect of the thigh or volar aspect of the forearm and there would be slight fever with occasional chilling, moderate nausea and vomiting and chest or abdominal pain. There frequently was the history of having just recently spent many hours on a working party, field problem or other activity requiring vigorous exercise. Recent trauma such as a sprain, fracture, bee sting or appendectomy would be followed in from one to seven days by the characteristic findings in the involved extremity or anatomically related area.

The writers whose experience was limited to Samoa have not emphasized the cases resembling acute pyelitis or renal colic. On our island we saw many men whose first complaint was costovertebral pain, mild fever and radiation of pain into the testicle. The urine would be negative except for a few red cells and flat roentgen-gram showed no stone. Within forty-eight hours the pain would leave the flank, gradually descend along the course of the ureter into the lower abdomen and finally into the respective spermatic cord where the obvious swelling could be palpated. So-called recurrent pyelitis was one of our earlier mysteries.

Too frequently an abdominal crisis would suggest acute appendicitis without much leukocytosis, but when we operated on these patients a normal appendix was found with moderately enlarged iliac glands and occasionally up to a liter of clear fluid in the pelvis. A few days later many developed genital symptoms of filariasis. Thus we learned to palpate carefully for pelvic glands in questionable cases. In a few men who had extremely scaphoid abdomens a lateral view would reveal the contours of swollen glands. Blood counts in all phases of filarial attacks were not helpful.

The marked periodic fatigue and mental depression was difficult to understand at first. Until most of the medical officers had experienced one or more attacks it was easy to accuse some of the men of "gold bricking." We were painfully embarrassed when inconsistent symptoms finally clarified themselves. We also began to understand the indolence of the Natives.

In summary, actual physical findings consisted in one or more of the following: acute retrograde lymphangitis on the medial surface of the thigh or the volar surface of the forearm or arm and in several cases the breast was acutely involved. There were retrograde red bands or streaks that were not hot and seldom tender, indurated lymphatic cords in arms, thigh and neck, palpable cervical, axillary, epitrochlear or inguinal glands, the elongated

spindle shaped inguinal nodes being most characteristic. The genital lesions showed swelling and tenderness of the spermatic cord in the inguinal canal and scrotum, orchitis, hydrocele, epididymitis, vasitis, varicocele and edema of the scrotal skin. Epididymitis and swelling of the spermatic cord was the most common genital lesion, being descending, retrograde or centrifugal. All findings were exaggerated by exercise and improved following rest. Differential diagnosis included mainly bacterial lymphangitis, appendicitis, pyelitis, renal colic, hernia, hydrocele and gonorrheal epididymitis. Huntington,<sup>7</sup> after extensive investigation of skin tests in which he employed extracts of the filaria found in dogs, has come to the conclusion that they have not proved of value in the diagnosis as they are non-specific among nematode infestations.

The mental reactions of the men were most interesting. There were three varieties:

1. A mental depression and irritability probably of a toxic nature, a state adequately testified to by the medical officer patients who had no anxiety about the genital lesions. Rome<sup>8</sup> has emphasized the Freudian interpretation of these states and in the frightened non-medical personnel it may well have significance. However many of us feel sure there is more than psychic trauma.

2. Sexual anxiety concerning the genital lesions based on fear for potency and fertility. The fertility of the natives and of the men newly married after return to the States can well discount that fear. Sections from the cords of natives have shown that the lesions about the vas are non-constricting.

3. The last group of psychologically concerned men were those who welcomed the disease as a potential ticket home. A few were known to have applied elastic bands about the scrotum at night to provide convincing swelling at sick call the next morning.

What of the future of these men? It appears that all is well. Since the disease does not reproduce itself without the intermediate mosquito vector it cannot progress outside of endemic areas where reinfection is expected to continue. Attacks that appear after returning to this country are explained by the disintegration of the worms that are still present. At Klamath Falls, Oregon, where thousands of these patients have been observed under the most rigid trial conditions, it is the opinion of the staff that the problem of filariasis is rapidly clearing and is largely a thing of the past. New admissions, recurrences and symptoms are rapidly disappearing and it is expected that the vast majority of those who have not already been, will be returned to full duty in non-endemic areas.

It should be emphasized that though some of the first attacks have occurred after return to the United States it is no reason for anxiety but rather is an indication that each recurrence indicates debility or death of the parasite and is a favorable sign, especially as the attacks become progressively more mild and at longer intervals.

No specific treatment has been found. The best results have been obtained following rest, evacuation from endemic areas, more rest, gradual increase in physical activity and reassurance. For many years antimony has been suspected of having some value. Recently it has received more attention but this writer is not familiar with its use or the results to date. The filariasis problem is becoming so unimportant that it is doubtful if antimony will be employed in this country in a sufficient number of cases to demonstrate its worth. In consultations with many of these returned patients I have been convinced that the proper explanation of the nature of the disease with reassurance is of paramount importance. Such discussions are particularly valuable when conducted by a

medical officer who has had the disease and has no anxiety about it.

For physicians in civilian practice who possibly may see cases of recurrent filariasis it should be emphasized that this disease must be added, for purposes of differential diagnosis, to the list of those diseases involving the reticulo-endothelial system and must be considered in the diagnosis of permanent or fugitive swellings of all kinds in men who have lived in endemic areas, especially swellings of the neck, axilla, groin, extremities and the genitalia.<sup>6</sup> It should be emphasized that removal of suspected glands is not necessary and may be harmful.

#### SUMMARY AND CONCLUSIONS

Filariasis in members of the Armed Forces serving in the Samoan defense Area was disease of considerable medio-military importance. It can be adequately though imperfectly controlled by reducing the breeding of the mosquito vector, restricting contacts with infected native populations, in their dwelling, recreational, and working areas, plus the use of protective clothing and mosquito repellents. Filariasis produced a high percentage of partial military ineffectives, though they were not incapacitated. When patients are removed from endemic areas and reinfection is no longer possible, the disease is self limited, the symptoms recur at increasingly prolonged intervals, and can be expected to disappear completely. It is not expected to be a public health problem even in parts of this country where the vector is present for the microfilariae have never been demonstrated in the blood of any of our patients, and the possibility that even one microfilaria might be transmitted is extremely remote. Civilian physicians who may see certain of the men who have served in endemic areas should consider filariasis in differential diagnosis lest error lead to inadvisable therapy.

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**Filariasis.**—Filariasis, the nasty tropical disease—the natives call it "Mu-Mu"—which some of the boys brought back from the boondocks of the South Pacific—nearly 10,000 men were eventually diagnosed as proven or suspected cases—is the reason Captain Lowell T. Coggeshall, MC, U.S.N.R., tropical disease expert, is receiving this year's Gorgas Medal, established by Wyeth Incorporated, in memory of Major General William Crawford Gorgas.

Captain Coggeshall convinced the boys that the disease—it causes severe aches and swelling in lymph glands and channels—not only could be cured, but would not, as they feared, leave them impotent or sterile. The birth rate among married men at the rehabilitation center at Klamath Falls, Oregon (Coggeshall had encouraged married men to bring their families) *was twice as high as the average for men in their age group!*



## ATELECTASIS OF THE NEWBORN\*

TREATMENT BY BRONCHOSCOPIC DRAINAGE

HAROLD OWENS, M. D.

Los Angeles

A TELECTASIS of the newborn has always been a serious condition and one which has been very difficult to treat. Unfortunately, the usual conservative measures in treatment are often inadequate, and the infant frequently expires of exhaustion.

Your speaker wishes to present the procedure of bronchoscopic aspiration to this group as an adjunct in the treatment of severe cases of congenital atelectasis due to obstruction of the bronchi by body secretions.

In order to present a better series of cases, he will include those bronchoscoped by Dr. Howard House. We have each done about an equal number of cases and arrived at the same statistical results while working independently. Twenty-three cases have been bronchoscoped during the past eighteen months and the results have been gratifying.

Woodward and Wadden<sup>1</sup> presented five cases of newborn atelectasis and quoted seventeen other cases of Dr. Maurice G. Buckles that were treated by bronchoscopic aspiration. Their article stimulated the interest of some of the pediatricians in the Los Angeles area, so that now bronchoscopy has been performed on twenty-three patients who had not responded to conservative therapy, and in which exhaustion of the infant seemed inevitable. It is the belief of your speaker that all the men who have had cases will agree that the type of patient that has been helped had been adjudged almost hopeless by them.

## PORTABLE INSTRUMENT

Very little equipment is necessary for the procedure and I have a portable set of instruments so the bronchoscopy can be done without moving the patient. This is very important in view of the extreme exhaustive state found in most of these infants.

## PHYSIOLOGY AND PATHOLOGY

According to Brennamen,<sup>2</sup> in intrauterine life the child's lungs are atelectatic. Twenty minutes after birth there is a 17 cc. air capacity, and three to six hours after birth the capacity is about 36 cc. Normally it is several days before the lungs have completely expanded. This expansion becomes complete first in the anterior borders and apices. The paravertebral, central and posterior portions are the slowest to expand.

Patterson and Farr<sup>3</sup> present strong evidence in support of the hypothesis that the human fetal respiratory tract is not inert in utero, but is subject to rhythmic respiratory movements, during which there is a tidal flow of amniotic fluid through the bronchial tree and alveoli. Examination of lung secretions of neonatal deaths, some stillborn, showed amniotic fluid present. That this is not entirely due to passage through the birth canal, as is generally thought, is shown by the fact that some of these cases were delivered by Caesarean section. Snyder and Rosenfeld<sup>4</sup> showed that India ink injected into the amniotic sac is followed shortly by the appearance of this material in the pulmonary alveoli of the animal fetus.

Wilson and Farber<sup>5</sup> feel lack of expansion in pre-matures is not a failure of respiratory effort in many instances, though this may be weak, but that it is due to cohesion of moist surfaces of the air passages. This condition may, of course, be emphasized by any disturbance

in the respiratory center, imperfectly developed thoracic mechanism or through obstruction of bronchi by aspiration of amniotic fluid, mucus or blood.

## INDICATIONS FOR BRONCHOSCOPIC INTERVENTION

The indication for bronchoscopic intervention is any condition in which there is mechanical obstruction of the trachea or bronchus, not correcting itself spontaneously or with the use of approved conservative therapy, and which appears to be leading to the infant's exhaustion.

## SIGNS AND SYMPTOMS

The classical picture of newborn atelectasis secondary to bronchial obstruction is herein presented:

1. Progressive dyspnea with cyanosis, most marked after crying or other effort. This may often be temporarily relieved with oxygen. When these symptoms are not present, listlessness and pallor are usually noticed.

2. Suprasternal retraction with diaphragmatic tug on the lower ribs and diminished thoracic expansion on one or both sides, associated with suppressed breath sounds with or without percussion dullness.

3. Coarse inspiratory rales and areas of localized emphysema. *Coarse moist rales are an important finding and are usually absent in cases not due to obstruction from body secretions.*

4. Dehydration.

5. X-ray of the chest will usually show a rather complete atelectasis of one or more lobes. An x-ray should be made when possible in every case, but the diagnosis is made primarily on the clinical picture.

## COMMENT

A case which fulfills the above requirements and which does not respond to the usual conservative therapy should be considered a candidate for bronchoscopic treatment. Because of the great variations in the clinical picture, and rapid changes in the condition of such infants, final decision as to need for treatment should rest with the bronchoscopist and pediatrician.

Twenty-three patients have been bronchoscoped with eight deaths, representing a mortality of thirty-four and seven-tenths per cent (34.7 per cent). In these eight patients with unfavorable ending, the diagnosis of true congenital atelectasis due to bronchial obstruction was not established with certainty prior to bronchoscopy. With some hesitancy, however, the patients were bronchoscoped, only to reveal little bronchial secretion. Subsequent post-mortem examination revealed that only two of the eight deaths were due to true atelectasis, and the remaining six patients were found to present cerebral hemorrhage, congenital aplasia of the brain, diaphragmatic hernia, pneumonia, congenital heart and massive patchy atelectasis not due to bronchial obstruction. The corrected mortality rate, after the above complications are eliminated, would be two deaths in seventeen cases of true atelectasis, or eleven and seven-tenths per cent (11.7 per cent).

Your speaker would like to emphasize that you not become overzealous in choosing cases. In view of the experience in the above instances, I feel it is imperative, prior to bronchoscopy, to rule out by every means at our disposal the various pathological entities that may resemble congenital atelectasis due to bronchial obstruction. These include asphyxia, congenital disease of the heart and blood vessels, congenital cystic lung, cerebral trauma, blood dyscrasia, pulmonary infection, diaphragmatic hernia and congenital fetal atelectasis.

Careful examination of the respiratory rate and rhythm of the infant will aid in eliminating distress due to cerebral injury.

Just what is the mechanism that makes the broncho-

\* Read before the Section on Pediatrics, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

scopy successful, I am not sure. In all patients mucus has been sucked from the bronchial tree, but in only one patient have I obtained a thick, stringy mucus plug from one bronchus. If cohesion of surfaces tends to promote atelectasis, perhaps instrumentation helps to relieve this condition.

Following bronchoscopic aspiration, there is usually a progressive improvement in the infant's respiration. However, complete relief most frequently occurs six to eight hours after instrumentation. This is apparently due to removal of secretions from the larger bronchi allowing the smaller terminal branches to drain.

Newborn atelectasis most commonly occurs in premature patients. In our series, nineteen of the twenty-three patients bronchoscoped were in this category, representing eighty-two and six-tenths per cent (82.6 per cent). The smallest infant treated was a four pound, four ounce (4 lb., 4 oz.) twin. Another weighing four pounds, seven ounces (4 lb., 7 oz.) and seven weeks premature, was likewise bronchoscoped and in both instances the infants went on to normal development.

The procedure of bronchoscopy seems to produce little, if any shock to these babies. Likewise, laryngeal edema does not develop secondary to instrumentation. This is due to two factors: first, the length of time consumed in the procedure is less than four minutes, and second, the type of bronchoscope used produces little trauma to the glottic chink.

The bronchoscope used is the new improved three millimeter bronchoscope devised by Dr. Simon Jesberg.<sup>6</sup> While offering the same inside diameter, it is about one millimeter smaller in its outside diameter than the old Jackson instrument. Consequently this instrument passes through the smallest glottic chink without difficulty, and subsequent laryngeal edema is prevented.

#### SUMMARY

1. The etiology of the newborn atelectasis is not fully understood.
2. Selected cases of newborn atelectasis secondary to bronchial obstruction, which fail to respond to conservative treatment, are materially benefited by bronchoscopic aspiration.
3. Most cases of atelectasis occur in premature infants.
4. Bronchoscopic aspiration of the newborn is a relatively benign procedure when properly performed.
5. The improved three millimeter Jesberg bronchoscope is the instrument of choice in cases of newborn atelectasis.

1052 West Sixth Street.

#### REFERENCES

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2. Brennaman: System of Pediatrics. Chap. 42, Vol. I, p. 46.
3. Atelectasis as cause of Neonatal Death. 4. J. C. Patterson, J. T. Farr: Canadian M.A.J. 41:31-37, (July), 1939.
4. F. F. Snyder and M. Rosenfeld: J. Am. Med. Assoc. 1937, 108:1946.
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*Girolamo Fracastoro (1484-1553).*—Fracastorius, as he was generally known, made his bid for fame in such varied fields as geology, astronomy, and poetry. In medicine, he is chiefly remembered by a kind of medical poem on syphilis, "Syphilidis sive de Morbo Gallico," from which the disease obtained its present name. In his book, "De contagione," Fracastorius gave expression to his idea of the germ theory in infection (seminaria contagionum), which bears a superficial resemblance to modern doctrine.—Warner's *Calendar of Medical History*.

## CLINICAL NOTES AND CASE REPORTS

### STAPHYLOCOCCUS AUREUS ENDOCARDITIS\*

TREATMENT WITH PENICILLIN—REPORT OF CASE

ROBERT E. HOYT, PH.D.

AND

FRANKLIN ELMORE BISSELL, M.D.

Los Angeles

SINCE the successful employment of penicillin in the treatment of bacterial endocarditis caused by *Streptococcus viridans*, numerous reports have appeared in which the drug has been used in *Staphylococcus aureus* endocarditis, with uniformly negative results. In the case to be presented, the diagnosis of staphylococcus endocarditis is supported by the prolonged bacteremia, the character of the murmurs, and the appearance of the emboliform lesions during the course of the infection.

#### REPORT OF CASE

Upon admission the patient, a 23-year-old white male, gave a history of an illness, several years previous, which had been diagnosed as arthritis with fever. Palpitations were stated to occur upon exertion. The immediate complaint was pain under the left scapula and moderate fever of one day's duration. Examination revealed a soft diastolic murmur over the aortic area, a loud P<sub>2</sub> sound, and acute pharyngitis. X-ray examination showed a moderately enlarged left ventricle. The temperature declined from a high of 100.8° F. on admission to 98° F. on the fifth day after admission. During this period the patient received sulfadiazine and sulfamerazine. On the fifth day after admission the temperature rose abruptly to 104° F. A blood culture taken at this time showed the presence of a coagulase-positive *Staphylococcus aureus*. A diagnosis of staphylococcus endocarditis was made, and sulfadiazine and sulfamerazine were given alternately, from 1 to 2 grams every four hours, from the sixth to the eighth day. On the ninth day after admission intramuscular penicillin therapy was begun, 10,000 Oxford Units being administered every 2 hours. Treatment was continued for 14 days, with the interruption of therapy on 2 days because of the lack of penicillin. Seven blood cultures were positive up to the eighth day of penicillin therapy; thereafter 12 cultures were negative and none positive. The patient's temperature fluctuated between 98.6° F. and 100° C. during the entire period of penicillin therapy. When 1,680,000 units of penicillin had been given, the lack of further supplies forced discontinuation of its use on the 23rd day of hospitalization. At that time sulfamerazine administration was resumed for 10 days (1 gram every 6 hours), during which time the patient's temperature became normal. He was discharged on the 34th day of hospitalization.

On the tenth day small red papilliform areas were observed on both hands, one foot, the forehead and on the back. These gradually disappeared during penicillin therapy. The blood picture was within the normal range during the entire period of illness except for a moderate leukocytosis (9,900 w.b.c. per cu. mm.) at the time of the highest fever on the fifth day.

At the present time, 18 months after admission to the hospital, the patient is free from all symptoms related to this episode. Blood cultures taken during the intervening period have been uniformly negative.

#### SUMMARY

In this case the clinical and laboratory findings indicate a *Staphylococcus aureus* endocarditis, possibly based upon an old rheumatic lesion, which failed to respond to sulfamerazine treatment. Prolonged penicillin therapy (1,680,000 Oxford Units were given over a period of 14 days) followed by sulfamerazine for 10 days, resulted

\* From the Institute of Experimental Medicine, College of Medical Evangelists, 312 North Boyle Avenue, Los Angeles 33, California.



in the disappearance of organisms from the blood stream and has apparently brought about permanent recovery.

## BLOOD TRANSFUSIONS AT THE SAN FRANCISCO HOSPITAL\*

J. C. GEIGER, M. D.

San Francisco

THE blood bank at the San Francisco Hospital began functioning in December, 1939. From that date to July 31, 1945, a total of 12,347 transfusions have been given, about 10 per cent using plasma, 90 per cent whole blood.

Case histories in which definite reactions were experienced have been reviewed only for a three-year period, (July, 1941-June, 1944). There has been no attempt to classify the diagnoses in which transfusions were indicated, infections, injuries, operative procedures and the like. Interest, rather, has been directed to the cases showing a reaction and the type of such reactions.

For the three-year period, 250 cases were found with reactions, a little less than 4 per cent of the total transfusions recorded in that time, 6812. The number of transfusions and reactions is shown by months for each fiscal year in Table 1.

As indicated in Table 2, chills and fever either singly or together were the reactions found in 151 or 60 per cent of the cases. Allergic reactions, urticaria, itching, hives, were found in 57 cases or about 23 per cent of them, while 19 or 7½ per cent showed jaundice.

In reference to jaundice as a reaction, it should be mentioned here that transfusions have been suggested as a probable cause for the appearance, after a comparatively lengthy interval, of symptoms resembling catarrhal jaundice.<sup>1</sup> Two such cases were noted in the records studied.

TABLE 1.—*Transfusions and Reactions—Blood Bank of San Francisco Hospital*

Months	1941-1942		1942-1943		1943-1944	
	Trans-fusions	Reac-tions	Trans-fusions	Reac-tions	Trans-fusions	Reac-tions
July . . . . .	190	11	183	7	185	5
Aug. . . . .	174	8	235	3	195	11
Sept. . . . .	168	10	205	3	206	13
Oct. . . . .	204	7	231	7	223	11
Nov. . . . .	149	8	138	8	147	6
Dec. . . . .	191	14	214	7	133	4
Jan. . . . .	157	3	273	10	165	5
Feb. . . . .	182	7	174	7	163	5
March . . . . .	192	6	233	8	191	5
April . . . . .	200	2	258	9	129	6
May . . . . .	140	2	277	12	190	3
June . . . . .	143	9	217	7	157	1
Totals . . . . .	2090	87	2638	88	2084	75
Per cent reaction	4.2%		3.3%		3.6%	

TABLE 2.—*Type of Reaction*

Type	1941 1942	1942 1943	1943 1944	Total	Per cent of total
Chills . . . . .	14	22	11	47	18.8%
Fever . . . . .	9	16	12	37	14.8%
Chills and Fever . . . . .	28	25	14	67	26.8%
Allergic . . . . .	23	14	20	57	22.8%
Jaundice . . . . .	6	3	10	19	7.6%
Hematuria . . . . .	2	1	..	3	1.2%
Hemoglobinuria . . . . .	..	1	1	2	0.8%
Hemolytic . . . . .	..	1	..	1	0.4%
Questionable . . . . .	5	5	7	17	6.8%
Total . . . . .	87	88	75	250	.....

\* From the Office of the Director, Department of Public Health, City and County of San Francisco.

CASE 1.—Lung abscess-multiple transfusions of whole blood, from December, 1943 to February, 1944, with no significant reaction. Readmitted to hospital May 3, 1944 with catarrhal jaundice.

CASE 2.—Injury-transfusion May 4, 1945, one unit each pooled plasma and whole blood. Ten weeks later, diagnosis jaundice. (Complete detail on this case not yet available.)

That blood transfusions do sometimes result fatally may be an established fact and it is possible that confirmation can be found in the blood bank records or autopsy findings; but statistically, where the only source of information is a briefed statement on a death certificate, assignment of a cause of death to this source is practically an impossibility. From records at the San Francisco Hospital three cases have appeared recently in which the cause of death has been attributed directly to blood transfusion. One of these has been discussed at some length by Captain Edmond C. Alberton, M.C., A.U.S.<sup>2</sup> In only one of these cases has the death certificate made any mention of the transfusion. In five other cases of record the evidence does not seem sufficient definitely to attribute the death to this cause, although it is a suspected cause and probably accepted as a fact in some instances. The death certificate in none of these cases makes mention of a transfusion.

101 Grove Street.

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Alberton, Capt. E. C., M.C., A.U.S.: Fatality Due to Transfusion of Unpooled Plasma, Am. J. Clin. Path., 15:4 (April), 1945.

### California Physicians to Promote Insurance Plan

The California Medical Association on September 7, announced plans for a Statewide campaign to promote voluntary health insurance. The purpose is to make medical and hospital care more generally available on a budget basis.

Through expansion of the California Physicians' Service, now having a membership of 190,000, the C.M.A. will attempt to meet growing demands for prepaid medical care. Other voluntary health insurance systems also will be promoted in the newspaper advertising and sales campaign, beginning early next year.

The plans were announced before the Assembly interim health care committee, at Los Angeles, and through the San Francisco C.M.A. office.

"We believe that within a period of a very few years the great majority of the people of our State, as a result of this program, will have their health needs cared for on a pre-payment basis," Dr. E. Vincent Askey, Speaker of the C.M.A. House of Delegates, announced.

The C.M.A. announced it still opposed compulsory health insurance and declared it believed the State government should encourage voluntary health insurance programs.

A statement of principles submitted to the Assembly Committee included prepaid medical care, and distribution of costs so as to guarantee the finest possible medical care and prevention of deterioration in the quality of service.

The statement stressed the necessity for voluntary rather than compulsory health insurance as best both for the patient and the doctor.

With the closing of war industries, many of which carried prepaid medical care facilities for workers and their families, sponsors of the California Physicians' Service, pioneered by the C.M.A., believe there will be an increasingly larger number of persons joining the C.P.S. system.—San Francisco Chronicle, September 8.

# CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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### OFFICIAL NOTICES

#### Concerning Relocation of Physicians Returning from Military Service

*California Procurement and Assignment Service for Physicians* has issued the important announcement which follows:

(COPY)

FEDERAL SECURITY AGENCY

*Procurement and Assignment Service For Physicians*

Room 1331, 450 Sutter Street

San Francisco, October 25, 1945.

1 1 1

TO: Chairmen and Members of the County Committees of Procurement and Assignment Service, Northern California.

FROM: Harold A. Fletcher, M.D., California State Chairman for Physicians Procurement and Assignment Service.

SUBJECT: *Relocation of Physicians Returning from Military Service.*

During the last few months since V-E and V-J days this office has been concerned with the problem of relocating physicians being discharged from the military forces. With the help and advice of the county chairmen and the secretaries and officers of the state and county medical societies certain definite policies have gradually been developed. As Chairman of the Procurement and Assignment Service for Northern California, as well as Chairman of the Postwar Planning Committee of the California Medical Association, I made a report of these policies to the meeting of the Council of the California Medical Association held in Los Angeles on October 21, 1945, and asked their approval of these policies. After thorough discussion, the following policies were given unanimous approval, and I am, therefore, giving you an outline of these policies in order that there may be general uniformity in the classification of physicians in your counties during the next six months or more when it is expected a large number of physicians still in military service will return to their former locations to resume private practice. These policies have been worked out on the assumption that every physician in California, who has served in the military forces, deserves every protection and help in becoming reestablished in his former location on his release from service. It further assumes that, until these men have had an opportunity to return to their former locations, every effort should be made to keep new physicians from locating in those places where their presence might seriously disturb the rehabilitation of the physician not yet released.

The State Chairman of Procurement and Assignment Service still has the responsibility of classifying physicians as essential or non-essential on the advice obtained from his county committees and other sources. The Procurement and Assignment Service has no authority to tell a physician that he can or cannot, or must or must not locate anywhere. However, during the emergency almost all county societies voluntarily passed regulations that, during the emergency, no new physician would be considered eligible to membership in the county society unless

† For complete roster of officers, see advertising pages 2, 4, and 6.



he was classified as essential by the Procurement and Assignment Service, as the Procurement and Assignment Service was and is the only agency authorized to so classify physicians as essential or non-essential. The county medical societies are now rightfully taking the stand that the emergency will not be over until there is more or less complete demobilization and there is a more or less complete return of physicians to their former location. These societies are, therefore, rightfully continuing to consider a physician ineligible who moves into a new location in which he is not classified as essential by Procurement and Assignment Service. This is of greatest importance, as you all know of the forecast of the intended location of thousands of physicians in California who previously practiced in other states.

The following policies should be followed, giving careful consideration to the merits of each case and making these policies flexible and commensurate with the actual needs of the various counties or areas and towns in the counties. *The needs of the various locations in the county for medical care should be based temporarily on present needs, assuming that a high percentage of physicians still in the service will have been returned.* If there is still a need for more physicians on this basis, room should be made for new physicians, and they should be classified essential if they choose to locate.

1. Physicians returning to former locations are immediately to be considered essential.

2. New physicians coming from previous locations in other states are not to be considered essential except under the necessities of the community as outlined above.

3. Physicians formerly practicing in another location in another county in California temporarily must be considered as non-essential to almost the same degree as a physician coming from out of the state. Such physicians should be advised to return to their former locations until the end of the emergency.

4. Young physicians who have never practiced anywhere before but who entered the military forces at the end of or during their postgraduate training. This group deserve the greatest care and consideration and help. In many cases these physicians would normally have entered practice in the towns or localities where they lived during their pre-medical educational years; however, this is naturally very often not the case. Wherever it can be shown that such physicians would normally have located in a particular area on the completion of their education, because of family, social, or medical contacts, or other reasonably legitimately valid reasons, they should be classified as essential and be given every help and consideration in establishing themselves. These young physicians will not in any sense interfere to any great extent with the return to practice of the older men. Exception to this statement may be lack of office space; and, where possible, these young physicians should be taken into association with older men in order to conserve office space. This group as a whole must be considered as the normal replacement of losses from the medical profession, aside from the temporary loss of physicians to the military forces. Preference should naturally be given to young physicians who have lived and been educated in California in their pre-medical years, regardless of whether they studied medicine in the state or out of the state. However, too much emphasis cannot be given to the importance of helping this group of veterans of this war in becoming established.

It is hoped that county chairmen, as well as secretaries of county societies, will interview personally as many of these returning veterans as possible. A personal interview, frankly stating the above policies, in almost 100 per cent of the cases will prove that the policies are fair and just, and the physician seeking location will be satisfied that

he has been given fair treatment and will express the hope that his own State Procurement and Assignment Service and medical societies are doing as much for their returning veterans as we are here in California. Furthermore, it should be clearly stated that these policies are only for the immediate future and will be abandoned on the termination of the emergency.

(Signed) HAROLD A. FLETCHER, M.D.,  
California State Chairman for Physicians  
Procurement and Assignment Service.

### How Santa Clara County Medical Society Carries Through on "Essentiality and Non-Essentiality in Civilian Practice"

*The Santa Clara Procedure is Called to Attention of All County P. and A. Committees*

#### I. LETTER FROM CALIFORNIA P. AND A. CHAIRMAN (COPY)

Federal Security Agency  
Procurement and Assignment Service For Physicians  
Room 1331, 450 Sutter Street  
San Francisco 8, California

San Francisco, November 2, 1945.

George H. Kress, M.D.,  
Secretary-Editor, *Addressed*.

Dear Doctor Kress:

I am enclosing a copy of a letter of October 24, 1945, from Fred W. Borden, M. D., Chairman of the Santa Clara Committee of Procurement and Assignment Service, which I believe might be given consideration for reprinting in CALIFORNIA AND WESTERN MEDICINE in connection with the problem of relocation of physicians during the immediate postwar period. His letter follows the line of his remarks and our discussion at the Council meeting in Los Angeles, and I feel that the way they are handling the situation in Santa Clara is very excellent.

With my kindest regards, I remain,

Sincerely yours,

(Signed) HAROLD A. FLETCHER, M. D.,  
California State Chairman for Physicians  
Procurement and Assignment Service.

#### II. LETTER FROM SANTA CLARA COUNTY P. AND A. CHAIRMAN (COPY)

San Jose 23, California, October 24, 1945.

Dr. Harold A. Fletcher,  
California State Chairman for Physicians,  
Procurement and Assignment Service,  
San Francisco 8, California.

Dear Doctor Fletcher:

Your apparent interest in the method of handling our Procurement and Assignment activities in Santa Clara County impels me to write this somewhat more detailed explanation.

As you know, Santa Clara County has never had more than 225 physicians. I estimate that since the start of the war this committee has had upward of 300 applications for approval of essentiality. These applications in 1943 and 1944 were entirely from civilian physicians outside of California who were in most part ready to leave a busy practice and come to California while starting would be easy. These inquiries were replied to promptly and courteously with the explanation that the local committee would be glad to consider the application as soon as it was cleared through your State Procurement and Assignment office. An explanation of Procurement and Assignment effort to secure equitable medical coverage for the

civilian population was then given, together with an after-thought, explaining that Vallejo and other localities were in much more critical need of physicians than was Santa Clara County, and for that reason I supposed that you would advise their locating at one of these points. This committee rarely received replies to these letters.

Since the accelerated rate of discharge of physicians from the Armed Forces has begun, we have interviewed between ten and twenty physicians per week who express a desire to locate in Santa Clara County.

This committee feels under considerable obligation to the physicians now being discharged and makes every effort to coöperate with them promptly.

In the first place, I picture myself in his shoes receiving information that before I can locate in a community it is necessary for me to submit an application to some "damned bureaucrat." My hair would raise a little under these circumstances. I would go to see this unknown bugaboo, feeling that he had no right to tell me what I could or couldn't do—I having fought the war, while he sat comfortably at home gathering in the shekels.

Now, if this bureaucrat kept me cooling my heels for two hours in his waiting room while he was busy with practice and I was in a hurry to get started on my own civilian practice, I would be doubly incensed.

For these reasons our committee members have instructed our receptionists to not let such a medical officer even get seated in the waiting room, but to bring him in immediately and introduce him.

We are genuinely interested in these men who fought the war, and are, of course, interested in learning where they have been and who they knew. In about three minutes, if the office is busy, we can ask the medical officer whether he has time for lunch and whether he would like to see a few civilian cases with us for a change. As a rule, the luncheon invitation is accepted, the man feels a justified personal interest, and the road is smoothed out for a friendly discussion of problems over the lunch table.

We try to record for future reference the name, rank, mailing and phone addresses, time in service and time overseas, age, medical school, postgraduate training, and type and location of previous civilian practice.

With these as a starter, we then explain that Procurement and Assignment has only one duty; namely, that of declaring a man essential to the community under the conditions which will obtain when our own physicians have returned to their practice.

Since Procurement and Assignment has occasionally never been heard of by the medical officer, we often explain that these committees are constituted under a Presidential proclamation as a wartime emergency, that we had a difficult time during the war inducing physicians to go to localities critically short of doctors, and that our present duty is principally advisory in assisting men to get properly relocated.

We explain that this duty certainly involves giving the highest priority of essentiality to any man who is returning to a practice which he left in order to enter the Armed Forces.

The second highest priority extends to those men who have never been in private practice but were commissioned directly from a residency, who have lived or had relatives in the community, and who have, to the knowledge of many of us, always expected to locate in the community, and who would have actually located here in recent years had their wartime service not been required.

Men who have practiced outside the State or inside the State are being urged to return to their former practices where they will, of course, have the highest priority to return.

We also explain that civilian physicians wanting to change location, rate the lowest priority at present.

We have found that at this point of the explanation the vast majority of medical officers will mentally classify themselves and will express approval of the fairness of this classification. In some instances, however, their personal interest supersedes their sense of fair play, and we then explain that Procurement and Assignment makes no attempt whatever to tell them that they may not enter the community—that if they meet the legal requirements of State licensure, they are free to go anywhere they like, but that they are thereby taking upon their own shoulders the full responsibility of achieving County Society membership and membership on the closed hospital staffs. We explain that staff membership is essential for practice in the hospital and that only County Society members are accepted as members of the hospital staff. In turn, the County Society by-laws provide that Procurement and Assignment approval is a pre-requisite to membership.

We usually explain then that in the absence of Procurement and Assignment approval, three or four men might come into the community and later be accepted by the Medical Society, but if fifty such men come in, they will probably all be classified the same by the membership at large, and friction will develop to their detriment as well as to the detriment of the community.

We have found practically every man interviewed to be quite reasonable when he has this kind of reception and explanation and frank discussion. Most men want to come into the community with the feeling that they are approved by their colleagues and are appreciative of the advice, time and effort.

This is best exemplified, perhaps, by a doctor from a mid-western state, who apparently came back to San Jose purposely to express his appreciation for the manner in which he had been received two weeks previously. He said that he was going back to his former location, because we had convinced him that the less moving about and disturbance and unrest in medical relocations, the better for him and for others, and he felt that his return to his former location was only temporary—perhaps a matter of two years—at which time he certainly hoped to make a move into the Santa Clara Valley where he had found such a "cordial turn-down." He hoped that his colleagues in his former location had done as well in preserving his practice for him as we had done by our boys here.

I would like to say, Harold, that our Santa Clara County P. and A. committee has worked faithfully and hard to the best of our interpretation of our duties. It is sometimes a back-breaking job, but we feel any man who has served in the Armed Forces is worthy of all the help we can give him. I also feel very keenly that unless this type of consideration is given by all your county Procurement and Assignment Committees, we will not be doing our best to foster good public relations within the medical fraternity. In view of the impending onslaughts on medicine by political groups, I feel we have a very practical as well as a sentimental reason for extending these courtesies.

Yours very truly,

(Signed) FRED W. BORDEN, M.D., *Chairman,  
Procurement and Assignment Committee  
for Santa Clara County.*

Let our object be, our country, our whole country, and nothing but our country. And, by the blessing of God, may that country itself become a vast and splendid monument, not of oppression and terror, but of wisdom, of peace, and of liberty, upon which the world may gaze with admiration forever.

—Daniel Webster, *Speech*, Charlestown, Mass., 17 June, 1825, at laying of cornerstone of the Bunker Hill Monument.



## OFFICIAL NOTICES

## TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

*Minutes of the Eighteenth (18th) Meeting of Members of "Trustees of the California Medical Association"*

Pursuant to call of the president and notice by the secretary duly and regularly given in accordance with the By-laws, a special meeting of the members of the "Trustees of the California Medical Association," a California corporation, was held in the Empire Room of the Hotel Fairmont in San Francisco, on Sunday, August 12, 1945.

## 1. Roll Call:

There were present: Philip K. Gilman, Sam J. McClendon, E. Vincent Askey, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, Walter S. Cherry, Edwin L. Bruck, E. Earl Moody, Dewey R. Powell, Edward B. Dewey, and George H. Kress.

A quorum present and acting.

## 2. Resolution Concerning Liquidation of Indemnity Defense Fund:

Report was made concerning the necessity of liquidation of the Indemnity Defense Fund and distribution of assets of the same. After discussion, the following resolution, upon motion duly made and seconded, was unanimously approved.

## Resolution Concerning Liquidation of Indemnity Defense Fund

WHEREAS, By resolutions adopted by the Council of the California Medical Association on June 29, 1940, and by the Board of Directors of this corporation, "Trustees of the California Medical Association," on June 29, 1940, all of the assets of the Indemnity Defense Fund were transferred from the Board of Trustees of the Indemnity Defense Fund to this corporation; and

WHEREAS, After the adoption of said resolution said transfer of funds was duly made, and the Board of Trustees of the Indemnity Defense Fund thereupon ceased to exist; and

WHEREAS, This corporation has since said time held all of the assets of the Indemnity Defense Fund in accordance with the terms and provisions of said resolutions; and

WHEREAS, This corporation, by virtue of written assignments and other transfers from contributing members of the Indemnity Defense Fund, is the legal and beneficial owner of 94.37 per cent of all of the assets of the Indemnity Defense Fund, and as to the remaining 5.63 per cent of said assets is the legal owner thereof subject to the beneficial interests of those contributing members of the Indemnity Defense Fund who are still living, active members in good standing of the California Medical Association, and who have not assigned their interests in the Indemnity Defense Fund to this corporation; and

WHEREAS, All of the purposes and objects for which the Indemnity Defense Fund was originally created have ceased and terminated, and there is no further purpose to be served by continuing the Indemnity Defense Fund in existence, or by continuing to segregate the assets formerly owned by said Indemnity Defense Fund for the other corporate assets of this corporation; and

WHEREAS, It is the judgment and opinion of the members of this corporation, "Trustees of the California Medical Association," that the said assets of the Indemnity Defense Fund should be distributed to the beneficial owners thereof, viz: this corporation and said non-assigning contributing members who are still living, active

members of the California Medical Association; now, therefore, be it

*Resolved*, That the officers of this corporation, "Trustees of the California Medical Association," are hereby authorized, empowered and directed to pay over and deliver from the assets of this corporation, which were received in 1940 from the Board of Trustees of the Indemnity Defense Fund, to each contributing member of said Indemnity Defense Fund who is still a living, active member of the California Medical Association and who has not assigned his interest in such fund to this corporation, that sum of money which equals each such contributing member's pro rata interest in the assets of the Indemnity Defense Fund; and be it

*Further Resolved*, That upon making payment and distribution of the assets of Indemnity Defense Fund hereinafter authorized the officers of this corporation shall first secure from each contributing member of the Indemnity Defense Fund to whom payment is made, a full release and receipt discharging and satisfying any and all obligations of the Indemnity Defense Fund, California Medical Association and this corporation, to such contributing members; and be it

*Further Resolved*, That when such payment and distribution has been made to each and all of the non-assigning contributing members of the Indemnity Defense Fund who are living, active members of the California Medical Association the remaining assets of this corporation which were received in 1940 from the Board of Trustees of the Indemnity Defense Fund shall be held and owned by this corporation free and clear of any trust or other obligation, and shall be comingled with the other funds and assets of this corporation; and be it

*Further Resolved*, That upon completion of the distribution and payment of the assets of the Indemnity Defense Fund hereinafter directed, said Indemnity Defense Fund shall be conclusively deemed to be fully liquidated, terminated and dissolved. (Note. For item in CALIFORNIA AND WESTERN MEDICINE, of Nov., 1920, see Twenty-Five Years Ago department, this issue, on p. 258. Total amount accruing from the liquidation is \$50,422.10.)

## 3. Adjournment:

There being no other business, on motion duly made and seconded, it was voted to adjourn.

PHILIP K. GILMAN, M.D., *President*,  
GEORGE H. KRESS, M.D., *Secretary*.

## COUNTY SOCIETIES†

## CHANGES IN MEMBERSHIP

## New Members (71)

## Alameda County (1)

Carson, Virgil H., *Oakland*

## Los Angeles County (56)

Alden, Charles, *Los Angeles*

Alexander, Harold B., *Santa Monica*

Amthor, John Graham, *El Monte*

Anderson, Richard A., *Pasadena*

Bailey, Elmore Russell, *Pasadena*

Belinski, Brunon, *Tujunga*

Boyd, Edwin F., Jr., *Los Angeles*

Bush, George, *Los Angeles*

Christoffersen, Leif E., *North Hollywood*

Cogan, James R., *Beverly Hills*

Collings, Clyde Wilson, *Los Angeles*

† Rosters of officers of component county medical societies are occasionally printed on page 4 of front advertising section.

Daitch, Morris B., *Los Angeles*  
 Davis, James Grover, *Los Angeles*  
 David, James H., *Long Beach*  
 Davis, Walter William, *Los Angeles*  
 Dunscombe, William Colby, *Long Beach*  
 Flynn, John Burke, *Burbank*  
 Furer, Stanford A., *Los Angeles*  
 Goren, Morris L., *Los Angeles*  
 Gorilla, L. Vincent, *Los Angeles*  
 Greger, Ernst, *Los Angeles*  
 Griesemer, Ruth Gorham, *North Hollywood*  
 Hannebaum, Otto P., *Los Angeles*  
 Hansen, Phil, *Long Beach*  
 Haskell, Maurice Mortimer, *Artesia*  
 Heuck, George William, *Altadena*  
 Jones, Margaret Holden, *Los Angeles*  
 Kloepfel, Chester S., *Los Angeles*  
 La Joie, Romeo J., *Los Angeles*  
 Lands, Victor Garde, *El Segundo*  
 Lang, Martin F., *Wilmington*  
 Leavelle, Robert B., *Los Angeles*  
 Lindsley, St. Claire R., *Los Angeles*  
 Lynch, Theodore Thomas, *Montrose*  
 Mason, Charles E., *Alhambra*  
 Merliss, Reuben, *Los Angeles*  
 Moran, William H., *Los Angeles*  
 Pilger, Erwin Samuel, *Long Beach*  
 Pressman, Abraham, *Los Angeles*  
 Redewill, Francis H., Jr., *Whittier*  
 Rubin, Herman, *Los Angeles*  
 Sive, Eugene Belmont, *Santa Monica*  
 Slocum, Yudell K., *Manhattan Beach*  
 Sommer, Melvin L., *Los Angeles*  
 Spicer, Charles, *Los Angeles*  
 Tandy, William, *Inglewood*  
 Thompson, Edith E., *Glendale*  
 Underwood, Laurence Joseph, *Los Angeles*  
 Vercellini, C. E., *Pasadena*  
 Vollmer, Henry W., *Glendale*  
 Warren, Edwin Douglas, *Santa Monica*  
 Wells, Carl Hunt, *Pasadena*  
 Wells, Lelia Hulbert, *Pasadena*  
 Wilkinson, Hildegard, R. J., *Glendale*  
 Wolf, Joseph, *Glendale*  
 Zachry, Ann, *Los Angeles*

#### *Monterey County (1)*

Carnazzo, William A., *Monterey*

#### *San Bernardino County (1)*

O'Connor, Owen, *San Bernardino*

#### *San Diego County (3)*

Lindsay, Charles W., *National City*

Shudde, Walter J., *San Diego*

Waters, Ethel M., *San Diego*

#### *San Francisco County (4)*

Champreux, Yvonne, *San Francisco*

Johnson, Stanley George, *San Francisco*

Jenkins, M. Elizabeth, *San Francisco*

Lowenhaupt, Elizabeth, *San Francisco*

#### *San Mateo County (1)*

Sultan, Ernest H., *Menlo Park*

#### *Santa Cruz County (1)*

Ritchey, J. L., *Santa Cruz*

#### *Solano County (1)*

Dans, Ernest A., *Vallejo*

Storey, C. H., *Vallejo*

#### *Ventura County (1)*

Maclean, J. A., *Ventura*

#### Transfers (2)

Kuhn, O. E., from *San Joaquin County* to *Ventura County*

Schneider, Kenneth F., from *Ventura County* to *Los Angeles County*

#### Retired Members (4)

Campiche, Paul, *San Francisco County*

Frick, Donald J., *Los Angeles County*

Holman, W. Frank, *Los Angeles County*

Roberts, William Humes, *Los Angeles County*

## In Memoriam

**Bretthauer, Carl Gottlieb.** Died at West Los Angeles, September 21, 1945, age 50. Graduate of the State University of Iowa College of Medicine, Iowa City, 1920. Licensed in California in 1930. Doctor Bretthauer was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



**Collins, John McGrath.** Died at San Francisco, September 2, 1945, age 36. Graduate of Creighton University School of Medicine, Omaha, Nebraska, 1935. Licensed in California in 1935. Doctor Collins was a member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.



**Frost, Kendal.** Died at Los Angeles, September 26, 1945, age 55. Graduate of Rush Medical College, Illinois, 1916. Licensed in California in 1920. Doctor Frost was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



**Gerlach, Frederick Christian.** Died at San Jose, October 4, 1945, age 76. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1894. Licensed in California in 1894. Doctor Gerlach was a member of the Santa Clara County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



**Kaelber, Arthur Proschold.** Died at San Francisco, September 6, 1945, age 67. Graduate of the Cooper Medical College, San Francisco, 1903. Licensed in California in 1903. Doctor Kaelber was a Retired Member of the San Francisco County Medical Society, the California Medical Association, and an Affiliate Fellow of the American Medical Association.



**Kramar, Lowell Graft.** (Lieutenant Commander, United States Navy.) Killed in action while serving in the Navy Medical Corps, place and date of death unknown, age 45. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1928. Licensed in California in 1928. Doctor Kramar was a member of the Humboldt County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



**Mansfeldt, John Harold.** Died at Pedro Point (San Mateo County), October 4, 1945, age 47. Graduate of Stanford University School of Medicine, Stanford Uni-



versity-San Francisco, 1927. Licensed in California in 1927. Doctor Mansfeldt was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Marsden, Charles Summers.** Died at San Diego, October 13, 1945, age 72. Graduate of the University of Michigan Medical School, Ann Arbor, 1903. Licensed in California in 1915. Doctor Marsden was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Shneerer, Joseph.** Died at Los Angeles, September 25, 1945, age 56. Graduate of Medizinische Fakultät der Universität, Wein, 1913. Licensed in California in 1940. Doctor Shneerer was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✱

**Smith, Edgar Daniel.** Died at Solvang, August 15, 1945, age 56. Graduate of the Chicago College of Medicine and Surgery, Illinois, 1913. Licensed in California in 1919. Doctor Smith was a member of the Santa Barbara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Sullivan, James McGeough** (Colonel, Army of the United States.) Died in a Japanese prison camp near Tokyo, January, 1945, age 52. Graduate of St. Louis University School of Medicine, Missouri, 1923. Licensed in California in 1923. Doctor Sullivan was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Wakefield, Rogers Fairbanks.** Died at Arcadia, September 3, 1945, age 45. Graduate of the University of Michigan Medical School, Ann Arbor, 1924. Licensed in California in 1925. Doctor Wakefield was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

## THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

### A Larger "Courier"

*The Courier* of the Woman's Auxiliary to the California Medical Association in its September (Vol. 9, No. 1) issue appeared in a new and attractive 8-page form, 9 by 12. The editorial staff (Mrs. Louis A. Packard, Editor; Mrs. Edwin B. Plimpton, Associate Editor), deserve much credit for the manner in which the enlarged "Courier" has made its appearance, both as regards contents and typographical format.

### Motion Picture Films and Slides on Public Health

A brochure, "Motion Pictures and Slides on Public Health" (California State Printing Office file number 47975, Sacramento), contains a list of many public health films, arranged by topics, and with information concerning Loan Agencies, etc.

The C.M.A. Postgraduate Committee sent to County Units of the Woman's Auxiliary to the California Medical Association, the letter below, which gives additional information.

\* \* \*

(COPY)

CALIFORNIA MEDICAL ASSOCIATION  
Committee on Postgraduate Activities

San Francisco, October 19, 1945.

*Component County Woman's Auxiliaries of the  
California Medical Association, Addressed.*

Dear Auxiliary Members:

The C.M.A. Committee on Postgraduate Activities is sending you herewith a copy of a brochure, "Motion Pictures and Slides on Public Health," containing a list of motion pictures and slides on public health put out by the California State Department of Public Health through its Bureau of Health Education (521 Phelan Building, San Francisco, 2).

The C.M.A. Committee on Postgraduate Activities is transmitting the brochure with the suggestion that the program committee of your County Auxiliary may wish to consider the occasional use of public health and related films at some of your meetings.

You will note that these films are available upon request to the Bureau of Education (Mrs. Ann Haynes, chief), and that there is no charge for their use "other than payment of return transportation by the borrowed."

The C.M.A. Postgraduate Committee takes the liberty of suggesting that presentation of one or more such films at certain meetings of your County Auxiliaries might give additional reason for extending invitations to officers and health committees of women's clubs and other lay persons in your County.

If the C.M.A. Postgraduate Committee can be of further service, feel free to inform us.

Cordially yours,

C.M.A. COMMITTEE ON POSTGRADUATE  
ACTIVITIES,

F. E. Clough, M.D., *Chairman,*

by s/ George H. Kress, *Secretary.*

## COMMITTEE ON ORGANIZATION AND MEMBERSHIP

### Doctor Shortage

We can detect no evidence of thoughtful planning in the war department's report to Senator Reed that the army had 506 more doctors on September 1st than on January 1st, when the war was in full progress in Europe and the Pacific. The shortage of doctors serving the civilian population has been acute for several years. In some communities doctors are working from 14 to 18 hours a day and are still unable to make the rounds to all who are sick.

This situation could be endured patiently so long as men were being wounded or contracting diseases at abnormal rates in foxholes and jungles. But, with the fighting at an end, it seems inexcusable to hold such a large number of doctors in the armed forces.

Of course, army and navy doctors must still be available to protect the health of men in uniform, and they have a big assignment in examining veterans as they are discharged. But we suspect the release of both doctors and dentists could be greatly accelerated without depriving the service of any essential medical talent.

Certainly, it would be difficult to show that the ratio

of doctors per 1,000 men served should be greatly increased when the fighting stops. Yet that is what the present policy, so far as it has been made public, appears to call for. Obviously, the need for doctors in the services should be more closely scrutinized in the light of the acute shortage at home.—Excerpt from *Washington Post*, appearing in *Modesto Bee*, October 13.

### Concerning 1946 C.M.A. Dues

The *Bulletin* of the Los Angeles County Medical Association in its issue of October 18, 1945, printed the following display item, in a special box:

(COPY)

#### ASSOCIATION DUES FOR 1946

Several months from now you will receive a statement for Association dues for 1946:

- (a) California Medical Assn. Dues, 1946.....\$100.00
- (b) Los Angeles County Medical Assn. Dues, 1946 17.50

Total Association Dues.....\$117.50

- (c) Voluntary Assessment (for Los Angeles County Medical Assn. Post-War Fund to assist returning members)..... 25.00

\$142.50

Due and payable January 1, 1946, to the Los Angeles County Medical Association, 1925 Wilshire Blvd., Los Angeles 5, Calif.

The House of Delegates of the California Medical Association in May set the State Association dues at \$100.00 for 1946 (a) in the belief that in these unsettled times with problems of reconversion, postgraduate education, rehabilitation of members returning from Service, and legislation pending, the California Medical Association should be in a strong financial position.

In all probability State Association dues will revert to normal in 1947.

Los Angeles County Medical Association dues (b) remain at the same level as last year—\$17.50.

Quoting the editorial in the *Bulletin* of September 20: "It might be well to put \$25.00 a month into the sugar bowl between now and the evil day, January 1st, just to soften the blow."

The voluntary assessment (c) is strictly a Los Angeles County Medical Association matter. The fund was started last year following action by the Board of Trustees placing a voluntary assessment of \$25.00 for each of the years 1945 and 1946. The need and value of this fund already is proved. The real need is approaching rapidly, now that the war is over and members are returning from Military Service.

### A.M.A. Conference on Public Relation Problems

(COPY)

*Public Relations Conference—Council on Medical Service and Public Relations—American Medical Association—October 19-20, 1945.*

10:00 A.M. Friday, October 19  
Assembly Room, 9th Floor, A.M.A.

Call to Order—E. J. McCormick, M.D., Chairman of Council, presiding

Welcome by H. L. Kretschmer, M.D., President of American Medical Association

Purpose of Conference—E. J. McCormick, M.D.

10:30 A.M.—Round Table Discussions

- (1) Legislation—Moderator, James R. McVay, M.D., Assembly Room, 9th Floor, A.M.A.

Wagner-Murray-Dingell bill, J. W. Holloway, Jr., Director, Bureau of Legal Medicine and Legislation

Hill-Burton bill and Scientific Research Legislation, Victor Johnson, M.D., Secretary, Council on Medical Education and Hospitals

Washington Front, Joseph S. Lawrence, M.D., Director, Washington Office of the Council on Medical Service and Public Relations  
State Legislation, T. V. McDavitt, Bureau of Legal Medicine and Legislation

- (2) Extension of EMIC program—Moderator, Thomas A. McGoldrick, M.D., Council Office, 4th Floor, A.M.A.  
Joseph S. Wall, M.D., President, American Academy of Pediatrics

H. H. Skinner, M.D., Chairman of EMIC Committee, Washington State Medical Association.

- (3) The Public Relations Job—Moderator, John H. Fitzgibbon, M.D., Lunch Room, 5th Floor, A.M.A.  
State and Local Programs

Publicity:  
Radio, W. W. Bauer, M.D., Director, Bureau of Health Education

Press, John Bach, Associate Director, Public Relations

Exhibits for the public, Thomas G. Hull, Director, Scientific Exhibit

- (4) Placement of Medical Officers—Moderator, James E. Paullin, M.D., Board of Trustees Room, 9th Floor, A.M.A.

Bureau of Information, Virginia Shuler, Supervisor Education and Post Graduate Opportunities, F. W. Arestad, M.D., Assistant Secretary, Council on Medical Education and Hospitals

12:45 P.M.—Luncheon

Kungsholm (631 North Rush Street)

- 2:15 P.M.—Watson B. Miller, Federal Security Administrator, Speaker, Assembly Room, 9th Floor, A.M.A.

2:45-4:45 P.M.—Round Table Discussions

- (5) Prepaid Medical Insurance Plans—Moderator, A. W. Adson, M.D., Assembly Room, 9th Floor, A.M.A.

Medical Service Plans, Frank L. Feierabend, M.D.

Indemnity Plans, Don C. Hawkins, Executive Assistant, St. Paul Fire and Marine Insurance Co.

Industrial Plans, Carl M. Peterson, M.D., Secretary, Council on Industrial Health

Coordination with Blue Cross, Jay Ketchum, Executive Vice President, Michigan Medical Service, Inc., Detroit

- (6) Rural Health Problems—Moderator, F. S. Crockett, M.D., Council Office, 4th Floor, A.M.A.

- (7) Activating Fourteen Point Constructive Program for Medical Care—Moderator, Louis H. Bauer, M.D., Board of Trustees Room, 9th Floor, A.M.A.

- (8) Veterans' Administration Plans—Moderator, W. R. Brooksher, M.D., Lunch Room, 5th Floor, A.M.A.

Paul R. Hawley, Major General, Medical Director, Veterans' Administration

William P. Holbrook, Colonel, Medical Corps, Legislative and Liaison Division, War Department  
Special Staff (Insurance Plane for Veterans)

Evening to Preparation of Reports

9:30 A.M.—General Session, Saturday, October 20  
Assembly Room, 9th Floor, A.M.A.

Reports of the eight moderators and acceptance of recommendations for action by Council

## COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

### New Medical School Proposed for California

*University of California Regents Approve Plans for Medical Department of University of California at Los Angeles*

The University of California is to establish a school of medicine in Los Angeles which it was indicated entirely unofficially, will call for the expenditure of several million dollars. A resolution to establish the school was passed on October 19, 1945, at a closed meeting of the university's Board of Regents at the Los Angeles campus.

The resolution follows:

"Whereas, there now exists throughout Southern California an urgent need for a medical school as a part of the educational system of the university . . . be it

"Resolved, That the Board of Regents forthwith estab-



lish a school of medicine in Los Angeles, and the president of the university is authorized . . . to take such action as may be necessary . . . including a request to the Governor that adequate budget provisions . . . be submitted to the Legislature at its next meeting, whether special or regular . . ."

#### Sixty Students at First

Dr. Robert Gordon Sproul, University of California president, declined to supply details on the scope of the project except to note that initial facilities would be provided for 60 students. This was interpreted by others to mean that the local school will have 60 in each entering class and that this would make it as large as the university's present Berkeley-San Francisco school of medicine which admits 65 new students each year.

Official confirmation was lacking for a report that, including hospital and research facilities, the school of medicine in Los Angeles ultimately will require a \$5,000,000 outlay. Dr. Sproul confined his explanatory remarks to pointing up the need for the school.

"The action was taken," he said, "on the basis of the fact that all recognize there is insufficient medical education in a rapidly growing center of population like Southern California. California now educates only a third of the new doctors it needs, two-thirds of the new men being educated in other parts of the country. As it now stands, three-fourths of all who want to become doctors must go outside the State for their education." . . . —Los Angeles Times, October 20.

## COMMITTEE ON INDUSTRIAL PRACTICE

### California Accident Commission New Board of Seven

Governor Warren at an early day will probably announce the names of his appointees to the new seven-member State Industrial Accident Commission created by the recent Legislature.

The new set up replaces the present three-member commission which included Paul Scharrenberg, State Industrial Relations director and commission chairman. Mr. Scharrenberg will now be able to devote his entire time to the gradually increasing job of head of the Industrial Relations Department.

The new commission will consist of three members from Northern California and three from Southern California. The chairman may be named from either section of the State. At least four times a year the entire commission will meet together to settle policy matters. Meantime, the chairman may devote himself to coordinating the work of the commission and helping out where needed.

It is understood that three Northern California members will be Everett A. Corten, who will be chairman; Alexander Watchman, a holdover from the Olson régime who will be reappointed, and W. A. MacDonald, Westwood. Mr. Corten is now chief counsel for the commission.

## COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

### U. C. Institute Study on Human Growth

Counteracting the tendency of modern science to increasing specialization in the plan of a few research groups in which scientists of related fields concentrate on the different aspects of the same problem in a joint

research, according to a recent article in the American Scientist.

Cited as one of the outstanding examples of this approach is the long research study on human growth which is being conducted at the Institute of Child Welfare on the Berkeley campus of the University of California, under Dr. Harold Jones, director of the Institute. This research has now been going on continuously for sixteen years and has maintained a record of the children from the time they entered the sixth grade through senior high school.

In this study the coöperative approach is the essential characteristic and at every step the study has rested not on the independent insight of a single investigator but on the interdependent work of a research staff which includes psychologists, physicians, a physiologist, and a school counselor. Other studies conducted at the Institute by Dr. Nancy Bayley, research associate, and Dr. Jean Macfarlane, professor of psychology, are concerned with the development of children from early infancy to maturity.

### California Mental Hygiene Legislation

In keeping with modern thinking concerning mental sickness, the name of the California State Department of Institutions was changed by Act of the 1945 Legislature to the Department of Mental Hygiene.

Two other changes in terminology reflect the change in attitudes. The Welfare and Institutions Code was changed to provide that patients be given "leave of absence" from State hospitals instead of "parole." Persons may now be committed to State hospitals upon being adjudged "mentally ill" and in need of care, supervision and treatment. Formerly, they could be committed only as being "dangerously insane."

The Legislature authorized the Department of Mental Hygiene to conduct outpatient clinics for the prevention, early diagnosis, and treatment of mental disorders and to conduct an educational program. The establishment of a clinic in Los Angeles was authorized and \$100,000 was appropriated for the purchase of land. In addition, \$20,000 was appropriated for the purchase of land to expand the Langley Porter Clinic in San Francisco.

An appropriation of \$207,000 for family care of mentally deficient persons will permit the placement of some of these people in private homes and relieve the overcrowding in the two State homes.

The sum of \$4,000 was appropriated for a Senate Interim Committee to study the problems of the care and treatment of the mentally deficient in California.

The State Department of Public Health was authorized to maintain a mental health service. However, no funds were appropriated for this purpose.

## COMMITTEE ON POSTGRADUATE ACTIVITIES†

### Medical Research as Seen by Chemistry Head of California Institute of Technology

Most backward section of the United States in medical research is Southern California, declared Dr. Linus Pauling, head of Caltech's chemistry department, who spoke in Pasadena on September 20. "Virtually nothing is done here on medical research," he said. "While there may be a few thousand dollars spent every year, this can't be compared with Harvard's \$500,000.

### Opportunity Offered

"This is a shame and doubly so when one considers that at the Los Angeles County Hospital there is the greatest opportunity offered for research in the country."

The scientist said that radar, which halted the inva-

sion of England with the aid of the R.A.F., was known in principle for many years before the war. As in the case of penicillin, the production of radar simply meant the spending of millions.

"In the case of the atomic bomb," he said, "all of the fundamental principles had been discovered in the 20's. By 1939 scientists knew the fundamentals, but not, for example, the proper size to be used. It cost \$2,000,000,000 to develop the bomb. But, two bombs ended the war and saved countless lives."

#### Used Up Backlog

The war, however, he continued, has used up the backlog of scientific discoveries. In the field of medical research, the average money used is \$5,000,000 a year. The war saw a boost in this amount to \$15,000,000 more. This despite the fact that medical research in 40 years has increased the expectancy of life from 47 to 63 years. In the war, not one member of the armed forces died of measles.

"Forty-five per cent of all deaths are due to heart and kidney diseases, yet only 17 cents per year per death is spent on research to discover cures of such diseases," he said. "The rate spent in cancer research is only \$2 per death per year, while \$500 per death is spent on research in the case of infantile paralysis."

#### Wartime Graduate Medical Meetings

Note.—The C.M.A. Postgraduate Committee presents below the roster of speakers and topics of "Wartime Graduate Medical Meetings." These listings may have suggestive value to program committees of Component County Societies.

##### CLINICS, DEMONSTRATIONS, LECTURES

Under the Auspices of the American Medical Association, the American College of Physicians, the American College of Surgeons

Authorized by the Surgeons General,  
Norman T. Kirk, Ross T. McIntire, Thomas Parran

##### Committee 24th Zone

Lt. Comdr. Geo. C. Griffith (MC), USNR, Chairman  
U. S. Naval Hospital, Corona  
Capt. Harry P. Schenck (MC), USNR  
Wayland A. Morrison, M.D.  
James F. Churchill, M.D.

Program of the Wartime Graduate Medical meetings for Zone 24 (Southern California) follow:

##### U. S. Naval Hospital, San Diego

Nov. 1—1:00 P.M.—"Dysenteries — The Differentiation Between the Protozoal and Bacillary Dysenteries," by Dr. John F. Kessel.

##### U. S. Naval Air Training Station, San Diego

Nov. 2—3:00 P.M.—"Recent Developments in Diabetes," by Dr. James Sherrill.

Nov. 16—3:00 P.M.—"Problems in Urology" by Lt. Comdr. Rusche.

##### Santa Ana Army Air Base AAF Regional and Convalescent Hospital

Nov. 6—3:30 P.M.—"Tuberculosis Problems," by Comdr. W. L. Rogers and Comdr. A. W. Hobby.

Nov. 20—3:30 P.M.—"The Use of Products of Fibrinogen and Thrombin in Otolaryngology," by Capt. Harry P. Schenck.

##### Camp Cooke Station Hospital

Nov. 7—1:00 P.M.—"Some Dynamics of Military Neuro-psychiatry," by Major Alex. Blumstein.

Nov. 21—1:00 P.M.—"Cardiac Emergencies," by Lieut. Comdr. Sylvester McGinn.

##### Hoff General Hospital

Same programs given at 1:00 P.M. at Camp Cooke Station Hospital repeated here at 8:00 P.M.

##### U. S. Naval Hospital, Corona, Calif.

Nov. 8—1:00 P.M.—"Neuro-Psychiatry," by Lt. Comdr. Nichols.

Nov. 22—1:00 P.M.—"Tumor Pathology," by Dr. Edward Butt.

##### U. S. Naval Hospital, Santa Margarita Ranch

Nov. 8—1:00 P.M.—"The Cancer Problem in the Service Personnel," by Lt. J. S. Binkley.

Nov. 22—1:00 P.M.—"Modern Concepts of Leprosy," by Dr. Maximilian Obermayer.

##### Birmingham General Hospital

Nov. 14—3:00 P.M.—"Surgery of the Biliary Tract," by Capt. Howard K. Gray.

Nov. 28—3:00 P.M.—"Thoracic Surgery," by Capt. W. L. Rogers.

##### U. S. Regional Hospital, Pasadena

Nov. 12—7:00 P.M.—"Thyroid Disease," by Lt. Comdr. George Crile.

##### Torney General Hospital

Nov. 6—3:30 P.M.—"Psychosomatic Medicine," by Major Milton Miller— one-half hour.

Nov. 6—3:30 P.M.—"Headache," by Capt. Oscar Sugar—one-half hour.

Nov. 20—3:30 P.M.—"Peptic Ulcer," by Dr. William Boeck.

##### March Field, AAF Regional Station Hospital

Nov. 20—3:30 P.M.—"Compound Fractures," by Comdr. P. E. McMasters.

##### U. S. Naval Hospital, Long Beach, Calif.

Nov. 21—3:00 P.M.—"Liver Disease," by Capt. John Ruddock.

##### Camp Haan ASF Regional Hospital

Nov. 6—3:30 P.M.—"Cardiac Emergencies," by Lt. Comdr. Sylvester McGinn.

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

### Blue Cross Hospital Service Director Opposes Wagner Plan

*Dr. C. Rufus Rorem Explains Purpose In Preserving Voluntary Health System*

Reasons for his organization's opposition to compulsory health insurance as provided by the Wagner-Murray-Dingell bill were recently outlined by Dr. C. Rufus Rorem, director of the Hospital Service Plan Commission.

The commission is the coordinating agency of 87 Blue Cross hospital service plans in the United States, Canada and Puerto Rico.

"We are interested," said Dr. Rorem, "in preserving the voluntary system of health service and of financing health service. We regard the Blue Cross and non-profit health insurance as having as broad a base of public interest as any Government proposal.

"We have no desire to protect any vested privileges or to maintain or increase the influence of persons associated with the voluntary program."

His organization, said Dr. Rorem, has urged that Congress act affirmatively to encourage voluntary health plans rather than to emphasize their inadequacies.

"We have recommended that Federal grants-in-aid



through the States be used for the payment of hospital bills or hospital service plan subscriptions for the low-income groups of our population," he said.

"This could be applied through payments to hospitals or to Blue Cross plans through the various State or welfare agencies.

"The use of Government funds to match payments by employed workers would permit Blue Cross plans to offer subscription rates within the ability of all employed persons to pay. Those requiring greater benefits could pay for them at the time of need. By 'greater benefits' I refer to luxury accommodations.

"The main difference between this and the Wagner-Murray-Dingell bill lies in that systematic health insurance would develop on a voluntary basis—with Government funds used as encouragement and assistance.

"We of Blue Cross observed with interest Senator Wagner's statement that 'voluntary health insurance plans would be permitted to continue mainly as instrumentalities of the Wagner bill rather than as non-profit agencies offered to the people as an alternative to the provisions of the Wagner bill.

"Blue Cross plans in Rochester, N. Y., and Cleveland have enrolled upwards of 60 per cent of their entire population."

### New Health Bills Seen for California

Expectations that the issue of compulsory state health insurance will again be raised when the California legislature meets in special session—now tentatively scheduled for January, 1946, is creating considerable planning on the part of both physicians and accident and health carriers in the State.

Already announced by the California Medical Association is a campaign for the promotion of group hospital plans that is arousing varied reactions among Accident and Health underwriters, and which is generally regarded as a proposal to prove that voluntary health insurance can work so well as to obviate the need for a compulsory program by the State.

Accident and Health carriers, meanwhile, are reported to be considering other methods by which private enterprise can meet the demand for more adequate health protection. There were three major attempts to secure the adoption of a compulsory State health insurance program at the regular 1945 session of the legislature. None of them was successful, although one had the vigorous support of California's Governor Earl Warren.

The campaign which has been announced by the California Medical Association is described by that body as follows: "To extend and expand California Physicians Service and other sound voluntary systems, display advertising will be used in every newspaper in California in an all-out drive to make the public 'health insurance conscious'—and to encourage the people to put their medical care on a budget basis."

The Medical Association outlines its objectives for health insurance with the following points: "(a) It must be voluntary and not compulsory in nature; (b) retain individual initiative in medical practice, so that the incentive for further advance in scientific medicine may continue; (c) fully protect the freedom of choice, both of the patient in choosing a physician, and of the physician in choosing a community, type of practice and professional procedures; (d) offer medical care in coöperation with allied services against serious illness or injury; (e) offer participation at cost within the means of all employed persons and income-receiving families; (f) provide a fair reward to those rendering the service which will give continued stimulus to scientific medical

development and sound medical practice." . . . —San Francisco *Underwriter's Report*, September 27.

### Caution Urged—Re: Wagner-Dingell Bill

In commenting on the proposed measure before Congress for socialized medicine, the *Christian Science Monitor* of Boston says the "bill better deserves the name of 'Omnibus Bill' than did Henry Clay's famous measure that so exercised Americans a century ago.

"Any social security legislation, however, holds three dangers:

"Paternalism, which goes so far as to remove individual incentives;

"Bureaucracy, which grows beyond the citizens' knowledge or control; and

"Political pressures for excessive expenditures.

"All social security proposals should be examined with these dangers clearly in mind."

The *Monitor* also published an editorial in which it is pointed out that the "revised legislation includes all that was in the original bill, yet proposes an initial cost only two-thirds as large. The expedients and figures offered are not convincing."

The *Mobile (Alabama) Press*, commenting on the *Monitor's* opinion, concludes that:

"This analysis by the calm-minded *Monitor* gives further reason why it is wise for the American people to proceed cautiously in regard to the latest proposal dangled before them . . . There is a vast difference between sound social security and impractical experimenting in social security at the expense of the public. There is much to support the impression that the pending bill overflows into the impractical, and in some respects the undesirable."

### Vote On Forum Findings

The following excerpt was a display bold face item in the *San Francisco Chronicle* of October 8, 1945:

Readers unable to attend the San Francisco Forum on peace-time community relationships are given an opportunity to indicate whether they agree with its findings.

Below is a ballot listing 10 of the most significant recommendations made by the five panels, which studied all phases of peacetime problems, and the audience.

Whether you agree or disagree, fill in the ballot and mail it to The Chronicle Forum. The ballots will be tabulated and the results published.

#### THE FORUM BALLOT

Here are ten of the most significant recommendations which came out of The Chronicle Forum on postwar community relationships.

Readers of *The Chronicle* can indicate their agreement, or disagreement, by filling in the ballot and then mailing it to:

The Chronicle Forum,  
The Chronicle,  
San Francisco 19, California  
Forum Ballot

As rapidly as the ballots come in to The Forum, they will be tabulated and the results published. The vote totals will indicate the amount of public interest, and its direction.

Do you agree?

Yes No

—A compulsory health insurance system  
should be set up

☐ ☐

Form Letter on Behalf of a Candidate for Civil Office

A postcard recently received, on reverse side gave a

photograph of a candidate for office, plus a sub-legend. On the face of the card in left third (reprinted here for suggested value) was printed the following:

*Dear Friend:*

*At the coming election on Nov. 6, 1945, my good friend,*  
(Name) .....

*will be a candidate for retention in office. He is eminently qualified in every respect for this office by reason of his splendid record. Your support and that of your numerous friends will be a personal favor to me,*

*Sincerely,*

(Signed).....

### Voluntary Health Plan Versus State Medicine

Despite high-power propaganda for "socialized medicine" both in California and throughout the nation a great many of the ordinary citizens who are supposed to be the principal beneficiaries of the new plan look with a good deal of skepticism upon any state control of medical services.

They are jealous of the privilege of going to the doctor of their choice when they need medical attention. And they don't like the prospect of having still another bureaucrat tell them what to do and when to do it when they get sick.

This feeling however, does not eliminate the obvious fact that far too many people feel themselves financially unable to have all the medical treatment they need with the result that the public health is not safeguarded to the extent it should be.

Statistics indicate that 95 out of 100 persons who reach the age of 60 either have had or will have hospitalization or surgery. In a good many instances this was the result of emergency need and brought unexpected expense to families which found themselves unable to assume it without considerable difficulty.

As a result of these facts both physicians and laymen have been seeking a solution to the nation's health problems for a good many years. And back in 1929 part of the answer, at least, was found when a method of prepaying the cost of hospital bills was organized and put into practice at Baylor University, Texas. A group of community-minded doctors and hospitals discovered that employed persons could, and would, pay the cost of illness and injury on a voluntary, non-profit prepayment basis.

From the Texas experiment emerged Blue Cross hospital plan that has brought aid and comfort to millions of Americans since that time. Worry over the cost of hospitalization is largely eliminated under the plan, with the result that today more than 19,000,000 Americans in 82 Blue Cross plans throughout the United States and Canada are availing themselves of its protection.

As Blue Cross expanded and proved satisfactory in meeting the needs for hospital care, the medical profession began to organize parallel plans throughout the country to give employed persons adequate medical and surgical care on the same voluntary non-profit basis.

California Physicians' Service is one of these. Now numbering approximately 90 per cent of the medical doctors of the state, it is sponsored by the California Medical Association and approved by the American Medical Association.

Practical experience in the operation of these doctor-hospital sponsored plans indicates that Americans are able, after all, to work out their problems on a voluntary, individual basis. It indicates that despite the nervous clucking of the do-gooders who do so much worrying about the "common man" he is pretty much able to look after himself when he is given any encouragement at all.

And it indicates that the doctors, convinced that the private practice of medicine is the way to good health

for everyone, are willing to do their part in making possible the continuation of the voluntary method—the American method—rather than the bureaucratic control which state medicine would bring.—Glendale News-Press, September 22.

### Heart Specialist Proposes a Health Day to Raise Funds for Medical Research

Dr. Samuel A. Levine of Boston, heart disease authority, suggested in San Francisco, on October 18, that a national health day be created to finance research for perpetual fight against all disease the same way the "March of Dimes" was developed by President Roosevelt.

He recommended that it be held on the birthday of a President, perhaps that of President Truman, adding:

Heart disease now is the "No. 1 public enemy in the field of health."

Fatalities are six times those from cancer.

They are three times those from meningitis, poliomyelitis, measles, scarlet fever and whooping cough combined.

For each \$500 spent on "polio" research, only 17 cents is available for heart disease research.

Endowments no longer are capable of meeting "the new needs" of maintaining national good health.

Dr. Levine's suggestion came between lectures at the sixteenth annual postgraduate symposium of the San Francisco Tuberculosis Association's heart committee at Stanford Hospital.

It was promptly indorsed by Colonel Irving S. Wright of the Marine Corps, medical consultant for the Ninth Service Command, and Dr. Louis E. Martin of Los Angeles, president of the California Heart Association.

Dr. Martin added his intent to place it on the agenda of the next Statewide meeting of the Association. No date has been set because of war conditions, but it is expected in the spring.

With more people dying from heart diseases than any other cause, Dr. Levine said the need for funding research has reached an acute stage. Medical science knows, for instance, that the Chinese do not get coronary heart ailments, but Americans do.

Doctors would like to know why this is true, he said, but it appears as if they won't be able to find out without conducting a world survey, and that is impossible on funds now available.

He suggested further that greater attention be paid to postgraduate education. Greatest emphasis now, he said, is placed on the education of the undergraduate—the person who is going to become a doctor—over a period of four school years, but virtually nothing is being done for education during the doctor's actual career, which normally spans 40 years, or 10 times his school training:

Medicine's greatest need, Dr. Levine emphasized, continues to be research, and it should be supplemented by "more adequate and general utilization of the knowledge we now have."

As an aside, he mentioned that President Roosevelt, who devoted a lifetime to the fight against "polio," died of a vascular heart disease.

Colonel Wright lent emphasis to the discussion by declaring that heparin and dicumarol, two relatively new substances still in an exploratory stage of development, have helped to revolutionize previous theories of blood clotting and unlimited possibilities are dependent upon financing of research.

It is entirely probable, Colonel Wright said, that further study of these two substances would be the doorway to a field which would prolong life. He emphasized the "experimental" nature of work to date but was definite about the accomplishments promised.



### Governmental Medical Care

Dr. Willford I. King, Professor of Economics, New York University, in a pamphlet put out by the Committee for Constitutional Government, referring to Public Medical Care, stated:

#### VIII. PUBLIC MEDICAL CARE

The C.I.O. also favors installing a system of public medicine. If this is done, it will again mean expanding the field of public activity at the expense of private enterprise. If the system as proposed is adopted, it will siphon into the public treasury most of the income now spent for medical care by the citizens. Past experience indicates when Government takes over any function the citizens gradually lose all control of the way that function is administered. Presumably, therefore, medical treatment will gradually be regimented to suit the whims of the administrators.

### Senate Bill 178 to Permit Chiropractors to Treat the Beneficiaries of the United States Employees' Compensation Act

(Excerpts from Congressional Report)

Congressional Subcommittee hearings on S. 178, a bill to amend the United States Employees' Compensation Act, were held in Washington, D. C., on May 16 and June 13, 1945.

The report of the hearings is printed by the United States Government Printing Office, Washington, D. C., and, for requests of copies, has reference printing number 76,286. The bill was designed to authorize the United States Employees' Compensation Commission to pay for services rendered by chiropractic physicians to Federal employees.

The report covers 104 pages and contains much comment of interest to physicians and also to citizens who believe that high standards of education and professional training should be demanded of all persons who seek licenses as practitioners of the healing art. For C.M.A. members who are interested, excerpts from this report are here printed:

The committee met, pursuant to call, at 10 a. m., in the committee room of the Committee on Education and Labor, United States Capitol, Senator J. William Fulbright (chairman) presiding.

Present: Senators J. William Fulbright, Smith, Morse, and Donnell.

Senator FULBRIGHT. The committee will come to order.

We are meeting this morning to consider S. 178, a bill to amend section 40 of the United States Employees' Compensation Act, as amended.

(S. 178 is as follows:)

[S. 178, 79th Cong., 1st sess.]

A BILL To amend section 40 of the United States Employees' Compensation Act, as amended

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the fifth and sixth paragraphs of section 40 of the Act entitled "An Act to provide compensation for employees of the United States suffering injuries while in the performance of their duties, and for other purposes", approved September 7, 1916, as amended (U. S. C., 1934 edition, title 5, sec. 790), are further amended to read as follows:*

"The term, 'physician' includes surgeons and osteopathic and chiropractic practitioners licensed by State law and within the scope of their practice as defined by State law.

"The term 'medical, surgical, and hospital services and

supplies' includes services and supplies by osteopathic and chiropractic practitioners and hospitals as licensed by State law and within the scope of their practice as defined by State law."

• • •

Senator FULBRIGHT. Senator Abe Murdock, the author of the bill, is the first on the agenda, and we will be glad to hear him.

STATEMENT OF HON. ABE MURDOCK, A SENATOR IN CONGRESS FROM THE STATE OF UTAH

Senator MURDOCK. Mr. Chairman, I first desire to thank you and also the other members of the subcommittee of the Committee on Education and Labor for giving us this opportunity to appear and consider S. 178. . . .

Senator SMITH. The only question I would raise is this: Being the son of a physician and very jealous of proper educational qualifications in any professional field, I just raise the question whether the State laws for admitting chiropractors are as stringent as they are for the medical profession generally.

Senator MURDOCK. I am not informed on that particular question. However, I think the Congress can very well rely on our States to see that our people in the respective States are given proper protection against quacks or any unqualified persons. . . .

STATEMENT OF HON. JOHN H. TOLAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

(Congressman Tolán represents the Oakland District)

Mr. TOLAN. Mr. Chairman and members of the committee, I wish to say, along the lines of Senator Murdock, that I too am the father of six children, so I have got him tied, and I have the finest doctor friends.

When I introduced this bill I had never taken chiropractic treatment in my life.

The first step we have taken was to add osteopaths on to physicians. In other words, by regulation of the Employees' Compensation Commission about 25 years ago they ruled that osteopaths and chiropractors did not come within the purview of physicians, don't you see? Now, that was started, and then they had some bills sent to them which they turned down on that ground.

I am going to be very brief about this because I know you are very busy and you have other witnesses. As to the merits of chiropractic and the medical profession, someone else will take care of that, but I do not see that that is involved, myself.

This is an employees' bill. The right for a Federal employee to go to a chiropractor if he thinks that he can help his back, for instance, that is all it is. It is permissive only, and it is up to the Employees' Commission to designate anyone they see fit in all parts of the United States, so it is again permissive with him. But anyway, be that as it may, there are about 20,000,000 chiropractic patients in the United States. In other words, the public can go to the chiropractor.

What this bill is aimed at is to permit the Federal employee to go there and get treatment and have the bill paid like he would if he had treatment from a physician. I cannot conceive how 20,000,000 people can all be wrong, I just cannot conceive of it.

You have about 12 to 15 million chiropractors. Some of the finest citizens in the District of Columbia are chiropractors, as far as that is concerned.

Senator FULBRIGHT. Did you say 12 or 15 million?

Mr. TOLAN. I am surprised I did not say billion, but I missed on that. No, it is twelve to fifteen thousand.

Now, the bill, gentlemen of the committee, just provides for this amendment:

The term "physician" includes surgeons and osteopathic and chiropractic practitioners licensed by State law and within the scope of their practice as defined by State law.

In other words, you only have five States in the Union that do not license chiropractors—five. They are not involved in this at all.

Senator FULBRIGHT. What are those States, while we are on that point, do you know?

Mr. TOLAN. The 43 States?

Senator FULBRIGHT. The five States.

Mr. TOLAN. We can get that for you. I have arranged for that.

Senator FULBRIGHT. All right.

Mr. TOLAN. Now, take Arkansas, for instance. There is nothing psychological about this, Mr. Chairman, but I just happened to pick Arkansas.

Senator FULBRIGHT. That is all right.

Mr. TOLAN. I would like to cite the digest of the statute of 1937:

#### SCOPE OF CHIROPRACTIC PRACTICE

A chiropractor may adjust by hand the displaced segments of the vertebral column and any displaced tissue and any matter related thereto for the purpose of removing injuries, deformity, or abnormality of human beings.

In other words, under this law they are absolutely limited, in the State of Arkansas, to that law, and they cannot go one step further. It is not obstetrics, it is not anything else. I am just citing that to give you an idea of the law.

Now, as to the legislative status of it, I took part in getting the osteopath in there, and that was enacted into law in May 1938; it passed the Senate and House and was signed by the President. This legislation is just to add on the chiropractor.

This bill has been reported favorably twice by subcommittees in the House and by the full committee last fall. The reason it was not heard, it was late in the session, and I was to blame for that; I did not have nerve enough to put it on the Consent Calendar, because I had three or four physicians watching me there, so I knew it would be objected to, and I did not try to get a rule. It was too late to get the rule, but it has been reported by two subcommittees in the House favorably, as well as the full committee. We expect to take it up again next week.

I have been interested in it, just like the Senator here, because I think it is a discrimination. I think if a Federal employee wants to go to a chiropractor, if he feels it will help him, I think he should have that right. He cannot do it now.

In addition to what you said, Senator Murdock, I do not know of a single governmental employee organization that is not in favor of this bill. We have put in the record here in the House hearing all who have endorsed it.

Again I say—and I am going to conclude with simply this—I do not think it is involved here, the merits of the chiropractic's profession as against the medical profession. I do not think it is involved at all. What is involved is the right for the Federal employee to go and get treatment there if he thinks it will help him.

Senator SMITH. Might I interrupt you?

Mr. TOLAN. Certainly, Senator.

Senator SMITH. It seems to me where you say the term "physician" includes surgeons, osteopaths, and chiropractic practitioners, you are practically bringing into the definition of "physician" groups that are not called upon by law to meet the same standard that the physician in practically all the States of this country is required to meet.

Mr. TOLAN. I see what you mean.

Senator SMITH. What I am afraid of is you will say to these Federal employees, "We think physicians are

so-and-so and you are perfectly safe in going to the chiropractor because he is a physician."

It is a misrepresentation of what we in the Federal Government believe should be the standards of a physician.

Mr. TOLAN. I see what you mean. But at the same time the Federal Employees' Compensation Commission has a right to designate, for instance, a chiropractor in my home city, Oakland, Calif., and under the Federal law no employee could be treated beyond anything within the scope of the California law, they could not do it, and that is all under the supervision of the Compensation Commission.

Senator SMITH. You mean they could not do it without violating the law.

Mr. TOLAN. Yes.

Senator SMITH. But they could practice and put their sign out as practitioners, they may do a lot of those things and nobody knows the difference.

Mr. TOLAN. You will find in nearly every one of those laws that they cannot hold themselves out as physicians, or call themselves doctors even.

Senator SMITH. Let me interrupt you a minute. The bill says, "the term 'physician' includes \* \* \* chiropractic practitioners," and therefore you say under the Federal law they are physicians.

Mr. TOLAN. Of course, that is defined, because the bill says "within the scope of their practice as defined by State law." That is why we put that in there as a safeguard exactly.

Senator SMITH. I misunderstood. I am not necessarily opposing this bill. What I am trying to do is to make a plea for the standards of medical practice. That is because of my profession and because I think it is so awfully important. I think a lot of fakers are going around who treat people today and who are not properly qualified.

\* \* \*

Mr. TOLAN. I guess there are fakers in every profession and every business, and that is why we were careful to limit it to "as defined within the scope of the State law."

Senator SMITH. Could we have in the record the data, or have you the data or any material to show the difference in the requirements of our State laws for physicians, for osteopathic practitioners, and chiropractic practitioners, so that at least our record will show that?

Mr. TOLAN. That will all be put in the record.

Senator SMITH. I would like to see that.

Mr. TOLAN. That is right.

Senator SMITH. Am I correct in this, that osteopathic practitioners are already included under the present law and the only change here is the words "chiropractic practitioner"?

Mr. TOLAN. That is all.

Senator SMITH. Therefore I would be interested in having the record show that a physician's preparation requires so many years of high school, medical school, and hospital training, the osteopathic profession requires this, the chiropractic profession requires that, so when we do report this out we know definitely what we are doing and we are not letting in any people who are not qualified and who are held before the public as properly qualified persons to take care of the illness.

Mr. TOLAN. We will see that you have the benefit of that in the record, Senator Smith.

Senator SMITH. I think that is important, because for a long time I have been troubled about the fact that the poorer people of the population are worked on by fakers, people who charge less and therefore they go to them, and if you place this person in a physician status and they go to him they get the wrong kind of treatment. I have had so much training in my youth with it in con-



nection with my own university work that I am terribly jealous of standards for professional services.

Mr. TOLAN. This thing was fought out in 43 States, but 43 legislatures finally approved it.

Senator SMITH. I see the force of that.

Mr. TOLAN. I think that is all. Thank you very much, Mr. Chairman, and members of the committee.

Senator FULBRIGHT. Thank you, Congressman.

The next witness is Mr. Clarence F. Stinson, assistant secretary of the National Association of Letter Carriers, Washington, D. C.

Senator FULBRIGHT. The committee will come to order.

The first witness is Hon. Arthur L. Miller, Member of Congress from Nebraska.

STATEMENT OF HON. ARTHUR L. MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Dr. MILLER. Do you want me to qualify myself first?

Senator FULBRIGHT. If you wish.

Dr. MILLER. I am a physician of 25 years' experience, a Fellow of American College of Surgeons, and I served for a year and a half as State health director in Nebraska.

I appear here in reference to Senate bill 178. This bill would give the chiropractors a right that is mandatory, I think, upon the Commission to permit them to treat Federal employees.

I think the Congress has a definite duty to protect citizens in the type of treatment that they might be receiving. . . .

I think there are some 20,000 chiropractors in the United States, and of that group I think you will find, from a careful analysis, that few of them had high school education. As the State director of health in Nebraska I had the background of the men practicing in that State, and some of them did not even have high school, but just grade school qualifications. . . .

SCOPE OF CHIROPRACTIC PRACTICE IN THE UNITED STATES  
Prepared by the Bureau of Legal Medicine and Legislation, American Medical Association, Chicago, May 1938,  
as supplemented October 1943

#### CALIFORNIA

Citation.—Deering's General Laws of California, 1931, Act 4811.

*Scope of chiropractic practice.*—A license authorizes the holder to practice chiropractic as taught in chiropractic schools or colleges and the right to use all necessary mechanical and hygienic and sanitary measures incident to the care of the body. It does not authorize the holder to practice medicine, surgery, osteopathy, dentistry, or optometry, nor does the act authorize the use of any drug or medicine now or hereafter included in materia medica. A licentiate cannot use the title "doctor" or the prefix "Dr." without the word "chiropractor" or "D.C." immediately following his name. He cannot use the letters "M. D." or the words "doctor of medicine," or the term "surgeon," or the term "physician," or the word "osteopathy," or the letters "D. O.," or any other letters or suffixes, the use of which would indicate that the licentiate was practicing a profession for which he held no license. Licentiates must observe and be subject to all State and municipal regulations relating to all matters pertaining to the public health, and shall sign death certificates and make reports as required by the law to the proper authorities, and such reports are to be accepted by the officers of the departments to which the same are made.

Senator FULBRIGHT. General Lull, we would be glad to have your testimony on this bill.

STATEMENT OF MAJ. GEN. GEORGE F. LULL, DEPUTY SURGEON GENERAL, UNITED STATES ARMY

General LULL. My name is Maj. Gen. George F. Lull, United States Army, Deputy Surgeon General.

Before proceeding, I would like to state anything I say has not been submitted to the Bureau of the Budget, nor am I informed as to the attitude of the President on this

program. I do wish to appear before the committee to state the status of chiropractors with reference to the Medical Department in the Army. I can state it very briefly, and that is that we do not have chiropractors employed, either as commissioned or enlisted individuals in the Medical Department of the Army. We base this on the fact that the soldier should receive the best possible medical care, and we do not believe that a chiropractor is competent to give the proper medical care.

STATEMENT OF DR. HERMAN G. WEISKOTTEN, DEAN,  
SYRACUSE UNIVERSITY, COLLEGE OF MEDICINE,  
SYRACUSE, N. Y.

Senator SMITH. Doctor, will you state your name and background for the record?

Dr. WEISKOTTEN. My name is Herman Weiskotten. I live in Syracuse, N. Y. I am dean of Syracuse University College of Medicine. I received my doctor of medicine degree from Syracuse University. I am a pathologist, and have been a member of the department of pathology of this college since 1910. I am a member of the council of medical education and hospitals of the American Medical Association, a member of the New York State Public Health Council and a member of the New York State Commission on Medical Care.

Members of the committee, my opposition to this amendment is stimulated by my interest in the medical care of the American public and in the field of medical education. The objective of medical education is to prepare individuals for the practice of medicine. The practice of medicine, regardless of any technical or legal definitions, is the prevention of disease and the treatment of sick or injured individuals, either with or without the use of drugs, apparatuses of various sorts, physical measures, or surgical procedures.

I am opposed to this amendment because as a pathologist who has performed several thousand autopsies, I know that there is no sound basis for the chiropractic concept of the causation and treatment of disease.

Senator SMITH. You are insisting that responsibility be taken by someone adequately trained and held out to the public as adequately trained for the care of the human body?

Dr. WEISKOTTEN. I am. That is my only contention.

Senator SMITH. Now, might I ask you this further question? Do you happen to know whether any formal investigation or scientific study has been made by American research men, say the American Medical Association, of the scientific merits of the chiropractic methods? Have they ever made any study of it so as to see what there is in the principle?

Dr. WEISKOTTEN. Certain individuals have made a study, and the whole development of medicine in regard to the study of the anatomy of the nervous system, the physiology of the nervous system, makes it perfectly obvious that there is no scientific basis for the construction that causation of disease in general lies in interference with nerves by displacement or subluxations of the vertebral column. It simply cannot be in a large number of instances. The nerves which come off from the spinal cord have nothing to do with the conditions which certain chiropractors feel are caused by such displacement.

Senator SMITH. It is your opinion that the theory is fundamentally wrong?

Dr. WEISKOTTEN. Yes; I am sure it is.

#### EDUCATIONAL BACKGROUND OF CHIROPRACTORS

In 1927, eighteen years ago, representatives of the council on medical education and hospitals of the American Medical Association inspected a number of the better-known chiropractic schools. A report of that inspection

was published in the Journal of the American Medical Association, May 26, 1928. . . .

Here is what the report had to say about the conditions found to exist in chiropractic schools:

"Chiropractic has had, during its brief career of 32 years, about 150 schools. Forty of these are still active, many of them offering courses at night only and having a mere handful of students; more than half of the 40 are so poorly housed and so inadequately financed that their future is problematic. B. J. Palmer, the 'developer' of the cult, recently said: 'According to our records, 48 chiropractic schools have closed their doors during the past 2 years.'

"An entrance requirement of 4 years of high school study or its equivalent is claimed by the best of these 40 schools; probably not one of them is enforcing the requirement. Mature age, business experience, ability to carry the chiropractic courses, or any convenient achievement is declared to be a satisfactory equivalent. A few schools give ridiculously short and easy high-school quiz courses and certificates, for which a special tuition fee is charged; this course in one of the leading chiropractic schools occupied 2 evenings weekly for 6 months. Fifty per cent or more of the chiropractic schools do not even claim to require a high-school education.

"The courses offered in the majority of these schools run through 'three school-years of 6 months each.' They are poorly chosen, poorly arranged, and poorly outlined. The student may begin on any school day of the year and finish on the same day of the eighteenth month thereafter. There are no adequate records of amount or quality of work done. Going to school is a matter of 'doing time,' and the student is given his doctor's degree as soon as the time limit expires. Legislation has forced a few schools to lengthen their courses to 24 or 27 months.

STATEMENT OF DR. FREDERICK J. QUIGLEY, EXECUTIVE SECRETARY, COMMITTEE ON LEGISLATION, THE MEDICAL SOCIETY OF NEW JERSEY, UNION CITY, N. J.

Senator SMITH. Dr. Quigley, as I am a New Jerseyite, myself, I am very glad to see you here.

Would you state your name and qualifications, Doctor?

Dr. QUIGLEY. My name is Frederick J. Quigley, of Union City, N. J. I am a physician. I am a past president of the Medical Society of New Jersey. . . .

The National College of Chiropractic in Chicago is referred to by most of my chiropractic acquaintances as the "best school." In May of 1944 I attended a meeting of the National Tuberculosis Association in Chicago. While there I visited the National Chiropractic College.

On page 11 of the catalog of the National College of Chiropractic the description of the course is headed "Chiropractic and Drugless Therapy Course." It is stated here that upon completion of the course—

The degree doctor of chiropractic is conferred and the degree of drugless therapy.

That is not all, however, that the college does in the matter of conferring degrees. The next paragraph reads:

Students who desire the degree of doctor of naturopathy can obtain this degree by including naturopathic subjects in their course.

The next paragraph is as follows:

Those who wish to obtain a license to practice mechanotherapy in the State of Ohio may qualify for this degree.

So a graduate of this school who intends practicing in Ohio would have had conferred upon him, upon completion of the course, the following degrees: Doctor of chiropractic, doctor of drugless therapy, doctor of naturopathy, and doctor of mechanotherapy. In the 1938-39 catalog of this school, page 11, is found the following:

Upon completion of this course the degree doctor of chiropractic, cum laude, is conferred and also either the degree doctor of drugless therapy, or doctor of naturopathy.

The statement that all graduates receive the degree "cum laude" is not contained in the last catalog of the school. It may be that the educational director of the National Chiropractic Association, Dr. Nugent, in his efforts to raise the standards of the schools, has suggested that this announcement does not look well in print.

## San Francisco Forum Submits Report on Social Insurance\*

The San Francisco *Chronicle* has been conducting a Forum on Governmental Relations and five panel reports have been printed. The panel report "On Government Relations With Industry and Labor" appeared in the *Chronicle* issue of September 23, 1945. Excerpts of interest to physicians follow:

This report concerns the rôle of government in meeting the transitional and postwar problems in our economy.

None of the problems discussed in this report will ever be settled until the people become actively interested in and well-informed concerning these public issues. Public forums in which everyone has an opportunity to take part can supplement the work which must of necessity be done by government and other research agencies. Dissemination of information to the people by all areas of government is essential to understanding and active participation on the part of the people.

PREAMBLE: This panel recognizes that the American people have an innate and historical distaste for governmental intervention in their economic system and in their lives as individuals.

At the same time, we recognize the historic truth that exercise of the power of government to intervene and control has been found to be necessary and has been most strongly developed in periods of depression and war, when the economic system is out of equilibrium.

Feeling that both the controls and the phenomena which give rise to them are equally to be discouraged, it is the consensus of the panel that governmental responsibility may be properly exercised to the extent necessary to assure equality of opportunity, to maintain economic stability, and to stimulate the continuing improvement of our standard of living.

Thus found necessary and thus delimited, it is the function of government to determine policy and to provide machinery for all segments or groups of the population to implement that policy.

We consider it important to emphasize that the Nation remains today in a true war economy—that the present period of demobilization is the third phase of one process of preparing for war, fighting the war, and preparing for peace. Governmental planning and direction of policy will be necessary to the extent indicated, both to assure an orderly transition from war to peace and realistically thereafter to cope with the ever-increasing complexities of the modern economy.

### SOCIAL INSURANCE

Social insurance should be strengthened and extended to all gainfully employed workers. With the exception of unemployment insurance, coverage should be extended to self-employed persons.

Benefits now provided for old age and survivors' insurance by the Federal Government and for unemployment insurance by the State Government should be revised and liberalized to bring these benefits in line with the new level of wages and prices. The panel recommends enactment of Federal legislation to provide supplementary unemployment insurance benefits at Federal expense, which will liberalize the insurance rates and the length of benefits provided by the State law and will extend benefits to Federal employees and Maritime workers, as a temporary measure for the reconversion period.

There should be added to the present Federal-State provisions for social insurance provisions for protection against the risks of illness and temporary and total disability due to non-occupational causes, including a compulsory health insurance system.

\* For other items in this issue of CALIFORNIA AND WESTERN MEDICINE, regarding "Forum" reports, see on pages 237 and 243.



### Chester Rowell's Comment on Panel Reports

(Cont'd from pp. 238-239)

Chester Rowell, well known publicist and member of the Commonwealth Club of San Francisco, and long one of the vigorous proponents of Compulsory Health Insurance plans (Mr. Rowell was chairman of two State Commissions and submitted reports to California Legislature urging compulsory health insurance) in his column in the San Francisco *Chronicle* of October 4, referring to the excerpts from The *Chronicle* Forum panel appearing above, commented as per quotation below:

#### Chester Rowell: Forum Panel Unanimous on Health Insurance

The panel on governmental relations with industry and labor reported to the full meeting of the San Francisco *Chronicle's* Forum, recommending among other things a strengthening and extension of social insurance generally, and, specifically, "a compulsory health insurance system."

This was the only panel having this subject before it, and it was unanimous. Its members represented all the general labor groups, including the A. F. of L. and the C. I. O., the ownership and management groups, the Chamber of Commerce, and business and capital organizations.

And its conclusions were the outcome of full hearings and careful examination of the whole subject. While the final action of the full Forum, and of others who wish to be heard, has not yet been taken, this conclusion has at least the moral weight of coming from the best-informed and most widely representative group having direct responsibility on this subject.

The fuller panel statement on this subject follows:

"There should be added, to the present Federal-State provisions for social insurance, provisions for protection against the risks of illness and temporary or total disability due to nonoccupational causes, including a compulsory health insurance system."

But when such matters, especially health insurance, come up, the political pressure group lobbies at once intrude themselves.

In this case, another panel, which did not have this question even before it, and had to be ruled out for want of jurisdiction, tried to put in a resolution against health insurance. Nobody imagined that this was the spontaneous act of this panel itself. On the contrary, everybody knew exactly what professional lobbyists were behind it.

Instantly, also, the politicians got aboard, from the outside. . . .

#### Another but Different Panel Report

CALIFORNIA AND WESTERN MEDICINE Note:—The report of one of the Panel Committees of the *Chronicle* Forum appears above.

Also comment from the column of Mr. Chester Rowell.

Of interest is a panel report printed several days later, on October 6, by another *Chronicle* Panel Group or Committee.

The two reports with their different recommendations indicate how easy it is to obtain divergent recommendations on the problems of health protection and hospitalization services.

Excerpts from the report of the Panel Committee on "Preserving the Democratic Way of Life" follow:

\* \* \*

#### Our Way of Life—Panel Report

##### HEALTH

(Note: Except for the recommendation on health insurance, the panel delegated to a group of experts the drafting of the health items and did not receive them in time to review or pass on them.)

#### Health and Medical Care Services

Essential health and medical care are basic to community welfare and are a prime responsibility of its citizens. Sound community planning places responsibility for its basic health services, including provision for medical care for the medically needy, on tax supported agencies. Voluntary agencies offer supplemental services in coöperation with existing public services.

#### Priorities in Health and Medical Care

##### 1. Health Education:

To maintain maximum health, citizens must be informed as to the values of health and the dangers of disease, shown what facilities are available to protect their own and others' health, and influenced to translate that knowledge into action.

To provide this information, the field of Health Education has been developed, and persons specially trained to direct these programs. Up to the present time, much of the activity in this field has been carried out by voluntary agencies. The positions of Health Educator in the Health Department and in the Schools should be created in all communities of any size, and all health education programs coöordinated under expert leadership.

##### 2. Psychiatric and Mental Hygiene Services:

Availability of psychiatric care is grossly inadequate. Psychiatric services need to be provided for those able to pay in full or in part, as well as for the medically indigent. Departments of Public Health, both State and county, need help in strengthening their programs. Since psychiatry is a field of medicine, these facilities should be developed as part of the existing medical care services of the communities.

Much of the present pressure on psychiatric facilities could be diminished by the provision of adequate mental hygiene services, such as child guidance clinics. In San Francisco, the child guidance clinics are all operating with maximum case loads and are unable to meet the demand.

##### 3. Dental Hygiene:

Like mental hygiene, the services and personnel are not sufficient for the needs of the community. There should be a full-time Bureau of Dental Hygiene in the Health Department, under the direction of a public health dentist. The school dental program, as well as other remedial dental care programs, should be extended as fast as personnel becomes available.

##### 4. Public Health Nurses:

To a very large extent the effectiveness of health facilities and the use of them depends upon the adequacy of the public health nursing program. A desirable ratio is one nurse to 2,000 population. San Francisco falls far below this standard, and the 1945-46 Health Department budget does not provide for additional public health nurses, although there has been a large population increase.

##### 5. Hospitals:

Hospitals in San Francisco, as well as in other large urban centers in California, are crowded, old and in need of replacement. Many hospitals are now planning the building of wings and modernization. Before these plans progress further, San Francisco and other Northern California cities should take under consideration combining their many clinical and hospital facilities in a few large modern structures.

If San Francisco is to maintain its reputation as the medical center of the West, it is necessary for its hospitals to be modernized and expanded. The use of hospital space for convalescents and chronically ill, as well as for the non-indigent tubercular patient, could then be wisely planned and provided.

The Hill-Burton bill (S. 139) will provide funds to States to enable them to make surveys of hospital facilities in communities. San Francisco should apply for these funds when they are available and have a study made of its needs.

It is recommended that health insurance is needed to assure to every person in California the opportunity for comprehensive medical services of the highest standard. It is therefore necessary to establish a contributory medical insurance plan to accomplish this purpose. It is urged that the public should study the many plans so far proposed, weigh their merits and make up its minds as to the best method to accomplish the ends desired.

### Samuel Gompers on Compulsory Health Insurance

The National Physicians Committee for the Extension of Medical Service, the Pittsfield Building, Chicago 2, Illinois, recently called attention to an address given in 1916 by Samuel Gompers, then president of the American Federation of Labor. The address appeared also in *J.A.M.A.*

The National Physicians' Committee introductory and the Gompers address, follow:

#### *What Is It? What Are the Implications?*

On May 24, Senator Wagner introduced in the U. S. Senate a Bill (S. 1050) Social Security Amendments of 1945. Congressman Dingell introduced an identical Bill (H.R. 3293) in the House of Representatives.

The key measure of these amendments provides for free medical, dental, laboratory and nursing care and hospitalization for all Social Security beneficiaries and their dependents—Compulsory Health Insurance.

These provisions are more far-reaching than any proposals ever previously presented in the United States Congress. They are more comprehensive than any measures enacted into law in any country with the possible exception of Russia.

They not only represent a departure from all precedents but they would establish a governmental machinery and administrative mechanism that are truly collectivist in concept.

In this country at this time there is a leadership of groups that would personally profit by the centralizing of controls. They would become the Gauliters or the sub-Fuehrers of a new order.

The leadership of the A. F. of L. and the C. I. O. Labor Unions are vigorously supporting the Compulsory Health Insurance Provisions of the Wagner-Murray-Dingell Bills. The rank and file of Labor do not understand the meaning and implications of these measures.

Times change and the points of view of men change with time—but there are basic principles governing human relationships that are eternal verities.

On December 5, 1916, a conference on social insurance was held in Washington to consider such problems as unemployment insurance, old age insurance and sickness insurance. Samuel Gompers, then president of the American Federation of Labor, speaking with deep feeling from some simple memoranda, warned organized labor of the threat inherent in the collectivist philosophy by which some leaders of labor are being seduced today. His address might well have been written as of today.

Hence, below are reproduced excerpts from this basic document, as published in the Bulletin of the U. S. Bureau of Statistics, No. 212, page 845.

AN ADDRESS BY SAMUEL GOMPERS, PRESIDENT  
AMERICAN FEDERATION OF LABOR

*Delivered in Washington, D. C., December 5, 1916*

For more than half a century out of my sixty-six years of life I have been concerned in the effort to try to bring

light and a greater degree of happiness into the lives and the work of my fellow men, and particularly of my fellow workers. I doubt if there be any one whose life is more attuned to the misery and the suffering of any one of my fellows than mine. With me it is the thought not only of helping to assuage immediate want or suffering but of maintaining the opportunities of men to struggle for right and for justice.

There has never yet come down from any government any substantial improvement in the conditions of the masses of the people, unless it found its own initiative in the mind, the heart and the courage of the people.

Take from the people of our country the source of initiative and the opportunity to aspire and to struggle in order that that aspiration may become a reality, and, though you couch your action in any sympathetic terms, it will fail of its purpose and be the undoing of the vital forces that go to make up a virile people.

Look over all the world where you will and see those governments where the features of compulsory benevolence have been established, and you will find the initiative taken from the hearts of the people.

There are certain species of compulsory social insurance that by their mere statement carry with them the conviction of their self-evident necessity and justice, into which the element of depriving the people of rights cannot enter—such as workmen's compensation and old age pensions.

But when compulsory health insurance and compulsory unemployment insurance are proposed, the question arises at once, what are the conditions and regulations to be imposed by the government to regulate the conduct of the supposed beneficiaries? . . .

The highest standards in the lives of the workers have been secured by the development, the organization and the exercise of the economic power of the workers. Although this economic power is superficially indirect, it is in reality the most potent and the most direct social insurance of the workers. It is the only agency that can readily guarantee to the workers protection against the results of the eventualities of life and give them a feeling of security.

There is more voluntary social insurance among the workers in the United States than in any other country in the world.

The organization of labor, which has secured reductions in the hours of their daily toil, which has secured higher wages and better standards of life, which has secured safety and sanitation, has done more to eliminate poverty and misery and unemployment and sickness than all other agencies of government and private individuals combined.

The trade-union of which I am a member and to which I owe my primary membership, in less than twenty-five years, as shown by absolutely accurate data, has reduced the sickness of its membership to a marked degree. It has lengthened the lives of the members of that craft on an average more than sixteen years. What is true of that organization is true to a greater or less degree of every other trade-union in America.

The organizations of labor provide social insurance in cases of sickness or unemployment far too little to be true to their mission, far too narrow to suit my impatient spirit; but the willingness to fly from the ills we bear to those of which we know not is quite too general among men who are well meaning, yet who are theorists, or who desire to indulge themselves in a fad that involves grave consequences not only to the workers themselves but to the fundamental principles of freedom.

Social insurance cannot even undertake to remove or prevent poverty. It is not fundamental and does not get at the causes of social injustice. The only agency that



does get at the cause of poverty is the organized labor movement. . . .

The labor movement aims at constructive results—higher wages, which mean better living for the worker and those dependent upon him, better homes, better clothes, better food; and shorter hours of work, which means relief from overfatigue and time for recuperation, workers with better physical development and with sustained producing power. Better physical development is in itself an insurance against illness and a certain degree of unemployment. The short hour workmen, with higher wages, become better citizens, better able to take care of themselves.

Then again, the first step in establishing compulsory social insurance is to divide people into groups, those eligible for benefits and those considered capable of caring for themselves. The division is based on earning capacity. This governmental regulation must tend to fix the citizens of the country into classes, and a long-established insurance system would tend to make those classes rigid.

Governmental power grows upon that on which it feeds. Give an agency power, and it at once tries to reach out after more. Its effectiveness depends on increasing power. . . .

Is it not discernible that the payments required of workmen for this compulsory social insurance interfere very materially with mobility of labor and constitute a very effectual barrier to the workers' determining their whole lives?

It seems to me that what we in America will have to do is to proceed on grounds that shall bring not only social insurance of a practically advantageous character but that shall help to develop individuality and personality and character and help to recognize the real struggle of the masses of the people, to encourage them in their struggle so that they may have the higher and the better opportunity for self development. What we should aim to do is to encourage voluntary associated effort of free individuals for their social insurance.

Industrial freedom exists only when and where wage earners have complete control over their labor power. To delegate control over their labor power to an outside agency takes away from economic power of those wage earners and creates another agency for power. Whoever has control of this new agency acquires some degree of control over the worker. There is nothing to guarantee control over that agency to employees. It may also be controlled by employers. In other words, giving the government control over industrial relations creates a fulcrum which means great power for an unknown user.

The introduction of compulsory social insurance in cases of sickness, or compulsory social insurance in cases of unemployment, means that the workers must be subject to examinations, investigations, regulations and limitations. Their activities must be regulated in accordance with the standards set by governmental agencies. To that we shall not stand idly by and give our assent. . . .

Men and women, I trust I may not be sounding my warnings on the empty air. I hope that they may find a lodgment in the minds and the hearts of my countrymen.

I bid you have a care in all these attempts to regulate the personal relations and the normal personal activities of the citizenship of our country ere it be too late.

There is in the minds of many an absence of understanding of the fundamental essentials of freedom. They talk freedom and yet would have bound upon their wrists the gyves that would tie them to everlasting bondage. And no matter how sympathetic or humanitarian is the gloss over the plan and the scheme, I again bid you beware. We know not when or how this great struggle going on in Europe will terminate, or what it shall mean

for the future of those countries; but at least let the people of the United States hold their liberties in their own hands, for it may come to pass that our America, the America whose institutions and ideals we so much revere, may be the one nation to hold the beacon light of freedom aloft and thus aid in relighting the torch, rekindling the heart flame of the world's liberty. . . .

For a mess of pottage, under the pretense of compulsory social insurance, let us not voluntarily surrender the fundamental principles of liberty and freedom, the hope of the Republic of the United States, the leader and teacher of the world of the significance of this great anthem chorus of humanity—liberty!

(End of Samuel Gompers' address)

## CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

### War Casualties Now 1,069,632

Washington, Oct. 18.—(AP).—A decrease in Navy figures brought the war casualty toll down again today to a combined total of 1,069,632 for the armed forces.

This was 521 under last week's count.

The Army total, covering casualties reported to the War Department through October 14 is 922,682, an increase of 99 from the previous week. The Navy total is 646,950, a drop of 620.

The Army casualties this week and a week ago: Killed, 208,966 and 207,754; wounded, 571,277 and 571,450; missing, 19,892 and 21,510; prisoners 122,547 and 121,829.

The Navy figures: Killed, 55,633 and 55,449; wounded, 80,238 and 80,240; missing, 9,543 and 9,763; prisoners, 1,506 and 2,118.

Of the Army prisoners, 105,354 have been listed as exchanged or returned to military control. Of the Army wounded, 364,128 have returned to duty.—San Francisco *Call-Bulletin*, October 18.

### World War II Deaths Four Times World War I Toll

Washington, Oct. 9.—(AP).—American Army deaths in battle in World War II are four times those of World War I.

In fact, more Americans died than in five earlier wars combined. These were the Revolutionary, War of 1812, Mexican War, Civil War (including both Union and Confederate deaths), and Spanish-American.

In these five wars 192,581 Americans lost their lives; the World War I figure was 58,510; the World War II figure is 205,000 plus.

General Marshall made the comparison in his chief of staff's report "so that there can be no understanding of the enormous cost of this conflict, for which we were so completely unprepared."

He spoke of lives lost and physical miseries involved, rather than money.

"There is no pay scale high enough to buy the services of a single soldier during even a few minutes of the agony of combat," he said.—Los Angeles *Times*, October 10.

### Points Lowered For Navy Doctors

Washington, Oct. 8.—(AP).—The Navy lowered its point score for the discharge of medical officers from 60 to 53 today.

An announcement said that 4,000 Navy Reserve physicians will become eligible for release under the new score by January 1, 1946. The Navy Medical Corps, both regular and reserve, has a present strength of 13,700. Under the 60-point score discharge system it is estimated that only 1,700 medical officers would have been eligible for discharge by the first of next year.—San Francisco *Examiner*, October 10.

### Twenty-seven Hundred Doctors Released During September

During September and the first four days of October, the Army Medical Department has separated 2,700 doctors from the service and by Christmas it is expected that 14,000 doctors will have been separated. Brigadier General Raymond W. Bliss, Acting Surgeon General of the Army, stated recently before the House Military Affairs Committee. Through the months of July and August approximately 1,300 doctors were released.

General Bliss pointed out that in proportion to the Army's 45,000 doctors on VE-Day, there are now 43,000 in service, 2,000 of whom are recent graduates of medical schools. With the high hospital load in this country, a large number of doctors are needed to staff hospitals and separation centers, which are now at peak operation. These centers require a total of 2,000 doctors.

Stating the approximate total of patients still in Army hospitals to be 400,000, General Bliss concluded, "You cannot treat patients without doctors. . . . According to the laws of Congress you cannot separate men without doctors. . . . By Christmas we will have reduced the number of doctors by at least 14,000, which represents more than 30 per cent of the total corps. At the same time, we will continue to meet our first and foremost responsibility to give the American soldier the best medical care that any soldier in any Army has ever received."

### Continuing Shortage of Doctors

#### *Release of 28,000 From the Services as Only Temporary Relief*

Evidence is accumulating that the United States is heading for a shortage of doctors and dentists. Within 12 months, 28,000 will be released by the armed forces. Their return to private life will bring some relief. It will solve none of the long-range problems.

The signs of shortage are developing at a time when there is a mounting need for civilian medical care, restricted during the war years. The shortage may be years in reaching its maximum, but the causes are now apparent:

**Draft** of 18-year-old students will cut the enrollment in premedical schools. It will be reflected in medical schools three years hence unless enough veterans and women enter training to fill the gap.

**Veterans' care** will take thousands of doctors out of civilian practice. The Veterans' Administration is making plans to care for 300,000 patients in the next 20 years. Anticipating a doctor shortage, it is quietly planning future hospitals near established medical centers. . . .

**Demobilization** of medical officers is through point systems. The Army and Navy are cooperating with the War Manpower Commission's Procurement and Assignment Service in the return of doctors to their private practice in communities that are in great need of their services now. That will bring relief, particularly during the coming winter. But the problem of the future cannot be solved by demobilization. That problem is to assure adequate medical care for the entire population. It is complicated by the fact that the trend among civilian doctors and dentists for years has been away from rural communities and toward the cities. Here is the outlook, by professional groups:

**Doctors.** Army and Navy now have 20,000 young doctors who never have been in private practice. If, upon demobilization, they establish themselves in areas of greatest need, medical care may reach normal peacetime levels by next spring. Should they settle in the cities to specialize, however, the over-all medical care of the nation will suffer and the distribution of physicians in ratio to the population will be worse than it is now.

The problem of medical protection for remote rural areas is attracting increasing attention of public health officials. To offset the medical trend toward the cities, the suggestion has been made that State universities offer tuition-free medical courses to students who agree to practice at least two years within the State in designated communities. . . .

The immediate job ahead is to spread the available medical care evenly over the entire population, and keep it there.—Washington, D. C., *U. S. News*, September 28.

### The Army Doctors

Disinclination of the Army to release physicians to civilian practice is not too well understood by the general public. The delay is garnering much criticism throughout the country, which is doubtless responsible for the circumstance that the Army is now taking certain steps to return some physicians to civil life although the program is observed by the inexperienced eye does not offer a great deal of relief.

The situation as it now exists is that 13,000 physicians, 25,000 nurses, 2,500 dentists, and many other Army medical department officers will be returned to civilian life by the end of this year. The effect of this upon the situation can better be determined after the program has been put into effect, and the rapidity with which it has been carried out has been observed.

So long as these physicians were needed for men overseas, none in civil life here at home would complain. The Army properly was given first call on their services and it was a huge satisfaction to us here at home to realize the excellent job the medical corps, both of the Army and Navy, was doing for our boys overseas.

But it is difficult to understand now, when there are so many service men being returned, thousands and thousands every month, that the public should be compelled to be content with shorthanded professional services. Certainly so many doctors are not needed now in the armed services as was the case under actual combat conditions.

Congressman Brown of Ohio, ranking Republican member of the House Interstate Public Health subcommittee, states he has received reports from doctors in the service that many of them are doing nothing but sitting around. The physicians themselves naturally enough, resent the situation. Concerning it, Mr. Brown said:

Everyone is in favor of giving our service men all the medical attention they need and the best of it. But it seems foolish to keep in uniform more doctors than are actually needed to do this.

The Army authorities must be aware the physicians who stayed home to take care of the civilian population while their professional colleagues went overseas to guard the health of American fighting men are entitled to a break quite as much as the civilian population.

Most of these medical men here at home have been working long hours, day and night, to respond to the calls made upon them. Many of them have broken down under these demands and are themselves in poor health as a result. They are clearly entitled now to an opportunity to rest and recuperate from the hard work they have been doing.

Every factor in the situation demands as many doctors be released from the armed services as is possible and as quickly. The war is supposed to be over. More



professional services here at home, and a better break for the medical men who have been doing the work here, ought now be available.—Editorial in *San Bernardino Sun*, September 26.

### Col. Lee Tells Commonwealth Club Army Doctor Has 160 Patients, Civilian Physician Has 1,000

While civilians who are lucky may have one doctor for every 1,000 residents of a community, in the army a doctor is assigned to every 160 healthy men, Col. Russel V. Lee, Palo Alto physician now stationed in Washington, D. C., told the Commonwealth Club at its weekly luncheon meeting Friday.

Colonel Lee has returned to Washington after a brief stay on this coast. After service at Santa Ana Army Air Base and a 60,000-mile tour of duty which covered combat zones, he is now with the bureau of preventive medicine of the Air Transport Command in the capital.

Colonel Lee anticipates his discharge from the army within a few weeks, his wife said today. Mrs. Lee was to leave today for Washington and planned to drive back to California with her husband. . . .—*Palo Alto Times*, September 17.

### Medical Care in Veterans' Administration

H.R. 4225 is the number of a bill introduced by Representative Rankin, by request, to establish a Department of Medicine and Surgery in the Veterans' Administration. It appears to be the bill a draft of which was discussed recently with the Committee on Postwar Medical Service by the Acting Medical Director of the Veterans' Administration, Major General Paul R. Hawley.

Indications are that hearings on the bill will be expedited by the House Committee on World War Veterans' Legislation. It is expected, too, that the provisions of the bill will be discussed during the course of the Public Relations Conference that has been scheduled by the Council on Medical Service and Public Relations for October 19 and 20, at the headquarters building in Chicago.

### Victory Loan

The War Finance Division, U. S. Treasury Department, Washington 25, D. C., calls attention to the following:

#### VICTORY LOAN

The war is over, but we haven't paid the bill for it. In addition to continuing sales, there must be one more big drive for extra bonds—the Victory Loan.

Why does the Treasury need \$11 billion in bonds when there is no longer a war?

Why should people buy Victory Bonds after the war is over?

*Why the Treasury Needs the Money:*

This is why the Treasury is asking for \$11 billion in the Victory Loan:

(1) *Care of the wounded and rehabilitation of veterans.* This job is going to be one of the nation's biggest expenses for years to come. Mustering-out pay, education, loans, and general administration of the G. I. Bill of Rights must be added to care of the wounded.

(2) *Cancellation and termination of war contracts.* Huge sums are still required to pay for war materials which were ordered, produced, and delivered months ago. Where contracts are canceled, payment must be made to contractors for losses suffered, and as contracts are terminated, companies drop out of the excess profits bracket

and our taxes go down, thus decreasing Federal tax receipts.

(3) *Inflation.* While unemployment will rise during the reconversion period, the big bulk of American wage earners will still be earning high wages and will have the most money accumulated that they've had for years. Present figures indicate that the "inflationary gap"—the difference between purchasable goods and services and income—will be about \$40 billion this year. In addition, Americans have accumulated about \$100 billion in savings since Pearl Harbor.

If this extra money is saved, it can provide a backlog of buying power and a steadying influence for years to come. Conversely, if people should try to spend it now before many consumer goods are available, chaos can result.

(4) *Bringing men home.* It's just as expensive as sending them over, and the process will go on for an indefinite period.

(5) *Maintaining armies of occupation.* Housing, feeding, giving medical care to at least two armies abroad is a costly business which will go on for sometime—we don't know how long.

#### *Why Should People Buy Victory Bonds Now?*

We believe the American people should—and will—lend their money to help pay our debts to the men who fought our war and were hurt doing so. We believe that the care of the wounded, the care of families of men killed, and the rehabilitation of veterans can be used to produce powerful and effective advertising for the Victory Loan.

We believe people will buy Victory bonds to help pay for bringing our men home.

And we believe that today, more than ever before, people will buy Victory bonds in their own self-interest.

In the past four years, the American people have shown excellent judgment, by and large, in their attitude toward bond buying. As individuals, as communities, as a whole, they have, through their bond buying, laid the foundation for a sound and prosperous post-war economy.

If the American people will exercise that same good judgment during the critical times immediately ahead, we have nothing to fear.

Today, nearly 90 million Americans own war bonds. Nearly 30 million have been buying bonds regularly out of earnings. These people have learned to save and like it. They have accepted bond buying as a method of attaining such personal goals as owning a home, educating children, starting a business. They like the idea of having an emergency fund for a period of post-war uncertainty—a period which is now hard upon us.

Furthermore, this is the last of the war loans. There will be no more. This is the final extra effort we will be called on to make. (Though E, as well as F and G, savings bonds will continue on sale, especially through the payroll savings plan.)

The Victory Loan begins October 29 and ends December 8. The overall quota, corporate and individual, is \$11 billion. The quota for individuals is \$4 billion—\$2 billion for E-bonds alone.

In all Victory Loan advertising, the bonds will be called Victory Bonds instead of War Bonds.

#### *Slogan and Insigne*

Slogan: "They finished their job—let's finish ours!"

Against the insidious wiles of foreign influence, . . . the jealousy of a free people ought to be constantly awake, since history and experience prove that foreign influence is one of the most baneful foes of republican government.

—Washington, *Farewell Address*, 17 September, 1796.

\* In a future issue of CALIFORNIA AND WESTERN MEDICINE, will appear the address by Dr. Lee.

## COMMITTEE ON HISTORY

### Gift of \$25,000 for Minnesota Medical History

The Minnesota Historical Society has announced that the Society has received a gift of \$25,000 from the Mayo Properties Association, Rochester, Minnesota. The money will be allocated for use in the writing and publication of a "History of Public Health in Minnesota."

The announcement stated that Minnesota, from its earliest days, had been a leader in the public health movement. Dr. Charles N. Hewitt, who came to Red Wing in 1866 after serving as a surgeon in the Civil War, was the trailblazer of the public health movement in Minnesota. It was his contention that Minnesota promote the fight for good health. Through his efforts, a Minnesota state board of health was established in 1872. Dr. Hewitt served as its head for twenty-five years.

It took time to bring about public thinking along his proposed lines, but much progress was gained as years went by. Quarantine for contagious diseases was made compulsory; vaccination was demanded; pure food laws were passed; a war against diseases in livestock was organized each effort a pioneer in itself.

With this background of pioneering in public health, the Minnesota Historical Society through this generous gift from the Mayo Properties Association, will be able to record for the people of the state what has gone before in the dynamic history of the public health movement.

The story of this movement, will be a major contribution to the history of Minnesota and its people. It will be of interest not only to the medical profession, but also to nurses, public officials, students of sociology and history, social workers, and a wide public.

Mr. A. J. Lobb, secretary of the Association stated "that the Board of the Mayo Properties Association appreciates the need for such a publication and the necessity for prompt action in order that the materials may be preserved and the story recorded by those now living."

The producing of the "History of Public Health in Minnesota," will open the way to monographs and special studies of aspects of the movement that cannot be dealt with in one general account. It will be important also as a contribution to a larger history of medicine in Minnesota which ultimately will be written.

### Los Angeles County Medical Association— Its Founders

In the *Bulletin* of the Los Angeles County Medical Association, issue of November 1, 1945, Editor E. T. Remmen, referring to the 75th anniversary banquet to be held on Thursday, January 31, 1946, makes historical comment as follows:

#### THE BUILDERS

On the evening of Thursday, January 31, 1946, there will be a banquet in commemoration of the 75th anniversary of the founding of the Los Angeles County Medical Association. Plans are still incomplete but the gathering will take place in the Biltmore Bowl. Honored will be our oldest members and past officers. Entertainment is to be excellent. The progress of medical organization and education since pueblo days will be the theme of addresses. Every member is urged to mark the date on his calendar. The occasion will be one long to be remembered, if we can equal the delightful evening at the Ambassador Hotel which marked observance of the fiftieth anniversary. On that occasion two of the three original incorporators then living attended the banquet. A postcard poll will be taken soon to ascertain how many will attend.

Until then it will not be known whether other than members can be invited. Probably no more than 800 can be accommodated and we have some 3,500 members.

As part of the observance, the Secretary's office is preparing a historical edition of *The Bulletin*. This will not be a tedious compilation of names, dates and details. It is not practicable, with the time and funds available, to prepare an encyclopedic volume which would be of interest chiefly to historians. The editors hope to present the story of the Association and related agencies and groups in a readable and well illustrated manner which will depict the aims, purposes and accomplishments of the medical profession of Los Angeles County. Chapters will be devoted to the medical schools, health departments, public and private hospitals. Significant addresses and resolutions will be included and unimportant detail omitted or presented in tabular form as far as possible. A large amount of material has been accumulated which will be of value for further study.

It has been a long and difficult but fascinating task to read the minutes, records and correspondence which have accumulated in three-quarters of a century. It has been necessary to study the entire file of *The Bulletin* which was first published early in the century. Prior to that, the activities of the Association were largely chronicled in the *Southern California Practitioner*, founded in 1886. The *California State Medical Journal*, now known as *CALIFORNIA AND WESTERN MEDICINE*, is another source. Old newspaper files, photographs in various collections, material in the Huntington and California State libraries, correspondence with living persons, and many other sources have been utilized. Publications by Drs. George Kress, John Shuman, Henry Harris and George Lyman will suffer extensive and shameless plagiarism. Since the first two are members of our county medical association it won't do them much good to complain. Actually, they have been of invaluable assistance and your editor is deeply in their debt.

This study has been of absorbing interest. One comes to feel comradeship with those pioneer physicians and profound admiration for their accomplishments in the face of difficulties which we can scarcely imagine. Picture Los Angeles in 1871 as a rather squalid village of 6,600 assorted whites, Mexicans, Chinese and others. There was no sewer system, no pavements and sanitation was nonexistent. Communication with the outside world was by stagecoach or by sea. Perhaps 16,000 people lived in the entire county which included what is now Orange County. The town did not lack doctors, but some of them possessed very little education. At that time quacks, as a rule, were either uneducated impostors who possessed no valid credentials or educated physicians who were advertising swindlers. Cultists were less common. The State Board of Medical Examiners was still unborn.

To this unprepossessing village came a handful of well-educated, brilliant medical men. Except Griffin, the Virginian, who had been here since 1846 when he came overland with General Kearney, they were young and recent arrivals. There was Edgar, veteran surgeon of four years with the Union Army, and Orme from Georgia, who had seen like service with the Confederate Army. Like the true scientists they were, they put aside the bitterness and hatred of fraternal war and worked together for everything that was good in medicine until death finally parted them. Widney, young, handsome, thoughtful and already distinguished for scholarship, was in the group. Hayes joined them and so did Rose and Dorr. Rose removed the following year from the city and we know little of him. Dorr acted as secretary at the first meetings. He wrote a beautiful hand resembling shaded engravings. Dorr moved to San Francisco in 1872 where he had a long and distinguished career, dying at the age of 94 in 1934. All



were graduates of fine Eastern schools except Widney who was from Toland Medical College, San Francisco. Remote and isolated from sources of scientific information, they yet resolved to make Los Angeles a center of medical culture of which they could be proud. If that aim has been accomplished the credit is largely theirs; if not, the responsibility rests with our generation and not upon them who laid so firm a foundation.

They founded a medical school only fourteen years after the organization meeting—a school which taught not medicine alone, but gave ideals and love of learning to its students. Its educational standards—if not its wealth—were equal to those of any medical college in the nation. They built hospitals, developed aseptic surgery, journeyed to far parts of the world in search of knowledge, published medical journals and worked for civic betterment. They were students of the classics and their writings are inspiring examples of learned, but clear and simple diction. As the years went on they were joined by excellent physicians from other cities and by their own students who took the torch from their failing hands and have carried it to greater heights. Let us study their lives and in reverence and humility keep vivid their memory.

## CALIFORNIA PHYSICIANS' SERVICE†

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### Beneficiary Membership

	August, 1944	August, 1945
Commercial Program .....	86,000	145,282
Rural Health Program.....	2,011	2,276
Housing Program.....	15,464	7,157
Total Membership .....	103,475	154,715

The Board of Trustees of California Physicians' Service held a regular meeting on September 9th, at the C.P.S. Offices in San Francisco.

The board approved the recommendation that all physicians and members of their families, as well as their nurses and secretaries, may become beneficiary members of C.P.S. This would allow those who take advantage of this to be covered for surgical operations, fractures and dislocations, and hospitalization for surgical as well as medical conditions for 21 days, plus one-half the cost for any stay immediately following this period, up to a maximum of 345 days. This will not only help C.P.S., but will help physicians taking care of other physicians or members of their families to be paid a fee for such care.

Legal counsel reported that the oral argument in the litigation with the Insurance Commissioner was set for

October 3rd. At this writing the court had granted the application for leave to produce additional evidence, continuing the case to January, 1946.

Mr. Anson Herrick, the Certified Public Accountant retained by C.P.S., appeared before the Board of Trustees and explained the new system of accounts, on which he had coöperated with the administration in developing. The new system is specifically designed, after much experimentation, for a prepayment medical care plan, and is geared to meet the financial affairs of C.P.S. in an efficient and economical manner in the event that large volume of membership is acquired in the coming years.

On Acquisition, it was reported that 10,233 persons were enrolled in August, and that the total beneficiary membership as of August 31st was 154,715. It was reported at this meeting that the percentage of lapse of membership due to unstable labor conditions was beginning to have its effect, and that approximately 30 per cent of new enrollment fails to get on the books.

In Professional Relations, it was reported that the membership has increased by 329 physicians during the past year. The attitude of physicians returning from service is also being felt, in that they express considerable satisfaction with the existence and growth of C.P.S. since they had left for service. Most of the service men are reaffirming their support of C.P.S.

The Public Relations Program continues, with a corps of speakers who have been talking to civic organizations and service clubs. This program will be integrated with the coming Public Relations Program of the California Medical Association.

On the Housing Program, the effect of the end of the war was being markedly felt in the Marin area, where the membership dropped to 55 per cent of the community. Marin area had always maintained between 80 and 90 per cent participation. Steps were taken for the possible discontinuance of the Marin Program. The Vallejo area will continue until evident changes warrant further consideration.

The board was acquainted with negotiations currently in progress to develop a new rural health program along the lines of the commercial program, wherein surgical and hospital benefits would be offered.

The fee schedule was submitted to the board by Dr. G. Dan Delprat, Chairman of the Fee Schedule Committee, who stated that a majority of the committee had approved the schedule as revised. The fee schedule was distributed to the members of the board for further study before final approval.

The board was in receipt of a letter from the National Physicians' Committee, indicating their desire to study the California Physicians' Service plan. The board issued an invitation to N.P.S. to make such a study.

The board was given a report by Mr. John Hunton, Executive Secretary of the C.M.A., on the activities of the Advisory Planning Committee of the C.M.A. This committee is acting in an advisory capacity on political and economic matters.

The C.M.A. Study Committee has held two meetings with representatives of C.P.S., in which a thorough discussion of the beginnings and the history and development of C.P.S. was had.

Dr. Alson R. Kilgore, former member of the Board of Trustees of C.P.S., was a guest of the board at this meeting.

CHESTER L. COOLEY, M.D., Secretary.

America is not to be made a polyglot boarding-house for money hunters of twenty different nationalities, who have changed their former country for this country, only as farmyard beasts change one feeding-trough for another.

—Theodore Roosevelt, *Speech*, Bridgeport, Conn.

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

## COMMITTEE ON MEDICAL ECONOMICS

### The American Way

It's the American way to throw tradition overboard whenever necessary to meet consumer demand for a good product, or create new markets for a better. Now California's doctors propose to take full advantage of our National trait, and really "sell" better health on a pre-paid basis to the people of this State.

The doctors, firmly convinced that the private practice of medicine is the American way to good health service for everyone, spearheaded the successful fight against compulsory health insurance at the last session of the Legislature. They were certain that State medicine, vigorously pushed by the C.I.O. meant poorer, not better health care for Californians, and danger to continued progress in medical science. The doctors had their own answer to the need for prepayment of health costs—voluntary health insurance.

More than six years ago the California Medical Association pioneered prepaid health protection through the California Physicians' Service, by which people can provide for sickness expense on a regular budget basis. The system has demonstrated that good medical service can be provided practically and economically without strangling patients or doctors in bureaucratic red tape.

Now the doctors plan to utilize newspaper advertising in a State-wide campaign with two objectives: First, to uphold their conviction that voluntary coöperation between the medical profession and the public will assure higher standards of medical service than any politically-controlled scheme of State medicine; second, to bring the benefits of their own California Physicians' Service to more people in the State.

When doctors prescribe a selling job for themselves—that's news. And if the job means better health for more people on a sound basis—that's good news!—*Orange News*, September 20.

### California Medical Association Proposes to Promote Voluntary Health Program

The California Medical Association, after pioneering the voluntary health insurance field for nearly six years with California Physicians' Service, this week announced plans to launch a Statewide newspaper advertising and sales promotion campaign early next year to expand C.P.S. and other voluntary health insurance systems until coverage is available to people in every walk of life who want to provide for their medical and hospital care on a budget basis.

Released simultaneously at the State office of the Medical Association in San Francisco and at a Los Angeles meeting of the Assembly Interim Committee on Health Care, the announcement quoted Dr. E. Vincent Askey, Speaker of the House of Delegates of C.M.A., as declaring:

"We believe that within a period of a very few years the great majority of the people of our State, as a result of this program, will have their health needs cared for on a pre-payment basis."

Still just as vigorously opposed to compulsory health insurance, or any other form of government-controlled socialized medicine, the Medical Association made public a statement of principles on health insurance which declared: "The function of State governments should be to encourage voluntary health insurance programs but not regiment the patient and medical profession, or operate compulsory health insurance plans established by political means."

Other basic points in the C.M.A. "statement of principles," submitted to the Assembly Committee by Stanley Cochems, executive Secretary of the Los Angeles County Medical Association, included:

"1. Any sound health insurance program should fulfill each of the following point: It is of primary importance that the people should be enabled to provide for the costs of illness on a regular budget basis during periods of good health and stable earning power, so that they may have medical-economic security. It is vital, however, that the distribution of costs should be undertaken in a manner which will still guarantee the finest possible medical care and which will prevent any deterioration in the quality of medical service.

"2. To serve the ultimate public interest any health insurance plan must: (a) be voluntary and not compulsory in nature; (b) retain individual initiative in medical practice, so that the incentive for further advance in scientific medicine may continue; (c) fully protect the freedom of choice, both of the patient in choosing a physician, and of the physician in choosing his community, type of practice and professional procedures; (d) offer medical care in coöperation with allied services against serious illness or injury; (e) offer participation a cost within the means of all employed persons and income-receiving families; (f) provide a fair reward to those rendering the service which will give continued stimulus to scientific medical development and sound medical practice."

When the campaign is launched early in 1946 to extend and expand California Physicians' Service and other sound voluntary systems, display advertising will be used in every newspaper in California in an all-out drive to make the public "health insurance conscious"—and to encourage the people to put their medical care on a budget basis.—*Los Angeles Star Press*, September 29.

### Medical Care Goals

Physicians of the United States are interested in extending to all people of all communities the best possible medical care. They stress the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated.

American enterprise has won the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled. Instead of socialized medicine, American doctors advocate a constructive voluntary program for the extension of improved health and medical care to all the people, as follows:

Sustained production leading to better living conditions.

An extended program of disease prevention in every part of our country.

Increased hospitalization insurance on a voluntary basis.

Extension to all localities of voluntary sickness insurance plans with provision for the needy under principles already established by the American Medical Association.

Medical care to the indigent by local authorities under voluntary insurance plans.

A survey of each state by qualified agencies to establish need for medical care.

Federal aid to states where needed, to be administered by local agencies.

Information that voluntary programs need not involve increased taxation.

Continuous survey of voluntary plans for hospitalization to determine adequacy.



Discharge of physicians from armed services as rapidly as possible.

Increased availability of medical education to young men and women.

Postponement of revolutionary changes while 60,000 medical men are in uniform to help preserve American democracy.

Adjustments in draft regulation which will permit students to study medicine.

Study of postwar medical personnel requirements of veterans' hospitals, army, navy, and U. S. Public Health Service.—*Van Nuys News*, September 17.

### California Compensation Refund

#### *State Compensation Fund Makes Big Refunder to Policy Holders*

More than \$5,000,000 is now being refunded by the State Compensation Insurance Fund for excess premiums collected on 1944 policies, it was announced yesterday.

The amount is one of the largest for any year since the fund was established in 1914, officials said.

The fund operates on the basis of furnishing insurance at cost. After payment of full compensation benefits to injured workers and setting aside reserves for all benefits that may become due in the future for injuries that occurred under these policies, the remaining surplus premiums are returned to policyholders.

Joseph J. Gallagher, manager of the State Compensation Insurance Fund, attributed the 1944 savings to "an effective program of safety engineering combined with complete service facilities and low operating costs."—*San Francisco Examiner*, October 30.

## COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

### California Assumes Legal Power to Supervise All Private Hospitals

The State Department of Public Health on September 17, assumed supervisory authority over all privately-owned hospitals in California, in accordance with a statute submitted by Governor Warren and passed by the last Legislature.

Governor Warren said the new legal authority to inspect, regulate and license hospitals, "fills an obvious need in the protection of public health.

The measure was recommended to the Legislature after Dr. William L. Halverson, State Director of Public Health, called the Governor's attention to the fact that "anyone could start a so-called hospital in a building entirely unsuited to the purpose, without adequate fire protection, sanitation and other desirable features."

Warren said a scale of inspection fees provided in the statute will make the supervision self supporting. An advisory board of hospital administrators will work with the Health Department in administration of the new law. Appointed to the board were Paul T. Elliott, Presbyterian Hospital, Los Angeles; Dr. Charles R. Poitevin, Osteopathic Hospital, Long Beach; Charles A. Wordell, Children's Hospital, San Francisco; A. A. Aita, San Antonio Community Hospital, Upland; and Dr. John C. Sharp, of Salinas, medical superintendent of Monterey County.

Exempt from the supervision are hospitals operated by government, state, cities, counties or the University of California. Also excluded are hospitals operated by religious sects who depend upon prayer or spiritual means of healing.

### Los Angeles County General Hospital Advisory Committee Called in Death Inquiry

Following an attempt by Supervisor Raymond V. Darby to revise regulations covering the labeling and handling of deadly drugs at the Los Angeles County General Hospital, the Board of Supervisors on October 22, agreed to confer with the citizens' lay advisory committee of the institution before any further action is taken.

Dr. Robert Millikan is a member of the committee.

Supervisor Darby's effort to revise the present system of handling drugs at the hospital follows the recent death of 14-year-old Pauline Estrada at the institution, resulting, it was asserted, from administration intravenously of a 20 per cent solution of chloride sodium instead of a normal saline solution by a resident in the osteopathic unit.

### Graduate Nurses Ask Pay Boost

Registered graduate nurses of California will ask for an immediate 15 per cent salary increase, followed as soon as practicable by a five-day forty-hour week, the California State Nurses Association announced today.

The request will be made to hospitals and other employers of nurses.

Miss Shirley C. Titus, executive director of the Association, said that vacation allowances, sick leaves, health programs and similar practice will be sought at the same time.—*San Francisco Call-Bulletin*, October 31.

### Blue Cross Plan

New York, Oct. 29.—General Omar Bradley, Veterans Administrator, has asked the American Hospital Association to consider the enrolling of all veterans and their families in the Blue Cross Hospital Service Plan, 200 leaders in the system learned today as the Association opened its three-day fall conference.—*San Francisco Chronicle*, October 30.

### Importance of Adequate Nursing in Hospitals (COPY)

#### CALIFORNIA HOSPITAL

1414 South Hope Street, Los Angeles 15, California  
Los Angeles, October 2, 1945.

To the Members of the Attending Staffs:

Last April you were advised that the hospitals in Southern California would increase the rate of pay to nurses and other employees, if such schedule was approved by the War Labor Board. The War Labor Board at that time denied the application. The War Labor Board has now issued orders allowing certain increases under certain conditions, and, we are, therefore, instituting the rates effective as of September 30, 1945. We are, therefore, establishing, effective at once, a new room rate schedule for both The California and the Santa Monica Hospitals. The rates will be effective on all types of cases, both in wards and private rooms.

We trust that this increase in the basic pay being paid in hospitals may encourage more workers. We are particularly short of nurses and other professional workers, and unless we get some relief, it may be necessary to curtail admissions. Our present high percentage of occupancy has been very difficult to handle. The workers have been particularly cooperative in taking on extra assignments in order that the many sick and injured may be admitted to the hospitals.

It has also come to my attention that many of our nurses are being offered positions in doctors' offices and taken from our services. I have asked our Director of

Nurses to give me a list of doctors making arrangements with our nurses before consulting the Director of Nurses Office. If we are to maintain our present schedule of admissions and occupancy, we must have the full cooperation of physicians in keeping our professional personnel. We would, of course, like to be of service in furnishing needed employees, but this should be done as we would do it, by first consulting the department head in authority to see how the arrangement could be worked out with the least disturbance to our regular service.

We also wish to emphasize that these new rates for ward cases will be less than the cost of service. These rates are only possible by spreading the cost between the private rooms and the wards. I also wish to announce that with these increases the hospital will always consider the economic status of the patient, if the physician will report the patients who have difficulty in paying the established rates, then such cases will be referred to the Social Service Department for consideration and an adjusted rate when all factors are considered.

We wish to thank you for your cooperation.

Very truly yours,

Lutheran Hospital Society of Southern California.

(Signed) MR. RITZ E. HEERMAN,  
General Manager.

### California Increases Tuberculosis Subsidy to Counties From \$3.00 to \$7.00

Senate Bill 25, providing for increasing to \$7 a week and extending the State subsidy paid to counties for the hospitalization of tuberculous patients, awaits only signature by Governor Warren to become a part of the State health and safety code, amending sections 3300 and 3301. The bill has been passed by the Senate and Assembly and the Governor has until July 25 to act on the measure.

Thirty years ago the State Legislature created the statute providing for a subsidy payment of \$3 a week per patient to counties maintaining a tuberculosis ward or hospital [that conformed to standards laid down by the California State Board of Public Health, through its Bureau of Tuberculosis]. Despite a steadily increasing cost of hospital care, the subsidy was not increased until the present amendments were passed.

At the beginning of the recently ended legislative session three bills, two in the Senate and one in the Assembly were introduced in the Legislature. The California County Supervisors' Association and the California Tuberculosis and Health Association were the sponsors of the Senate bills, which also had the approval of the State Department of Public Health. Local tuberculosis associations also were active in support of the measures.

The Senate committee on public health and safety incorporated the features of the bills into Senate Bill 25.

### "The 1945 Hospital Review"

#### To Substitute for National Convention

A series of publications containing data of both contemporary importance and lasting interest to hospital administrators and the hospital-minded will take the place of the 1945 convention of the American Hospital Association. Entitled in its entirety as "The 1945 Hospital Review," the series will deal with current developments in hospitals' problems and outlooks for the future.

To be distributed early in October, the first of the series, "The Individual Hospital," will be composed of three book sections and a preface. The book sections include "Measuring the Community for a Hospital," "Or-

ganization of Governing Board and Medical Staff," and "Administrative Aspects of Hospital Construction," all prepared by Dr. Warren P. Morrill, research director of the Association. The preface to these sections will contain contemporary definitions of the hospital in relation to the physician, the trustee and the administrator. The definitions are being contributed by recognized spokesmen in these fields.

Each of the three book sections has been submitted for criticism to more than thirty leaders in the professional fields. Pertinent comments thus gathered have been incorporated into the text to afford two viewpoints on controversial subjects. Each of the book sections will be reprinted and sold as separate publications for distribution in answer to requests.

"Economic Issues Facing Hospitals," treated in six book sections, will comprise the second in the series. Public leaders and officers and headquarters personnel of the Association will prepare material on economic issues facing hospitals, U. S. Senate Bill 191, government payment for hospital care of indigents, care of the veteran in community hospitals, the Blue Cross prepayment plans, and the Commission on Hospital Care.

The third publication, "Activities and Business of the American Hospital Association," will include addresses by the outgoing and incoming presidents, Dr. Donald C. Smelzer and Dr. Peter D. Ward respectively, in addition to reports of the Association's bodies and a summary of its activities during the year. Transactions of the House of Delegates meeting will also be published in this third book.

"Hospitals must prepare for a period of sweeping changes, as must enterprise of all kinds," said Dr. Donald C. Smelzer, retiring president of the Association. "Problems created by the war emergency are now changing into problems of readjustment; these will give way—perhaps during the next twelve months—to the longer-range problems of reconstruction. Never in the Association's existence has it been so important that hospitals have a current perspective to their problems—a 1945 perspective as taken in the American Hospital Association's 'Hospital Review.'"

### American Hospitals

In a recent issue of *Survey Graphic*, appeared an interesting article by Michael M. Davis on "The Legs of the Hospital Bed."\* Brief quotations from same follow:

During the past seventy-five years, the population of this country has increased less than four times, Ninety-five per cent of the five billion hospital capital has been contributed on a non-profit basis by governments or private agencies or individuals. Here is big business without stockholders or dividends. Local, state or federal governments own and operate a third of the 6,600 hospitals, and have 1,350,000 out of the 1,700,000 beds. The government figure is swelled by 400,000 federal beds added since 1940. State and local governments have largely preempted hospital care for mental diseases and for tuberculosis.

The non-governmental hospitals receive a larger proportion of the acute, short-term illnesses. For this reason ten million of the sixteen million hospital admissions last year were to non-governmental hospitals. These voluntary hospitals outnumber the governmental hospitals two to one. They are the typical American general hospital. Their boards of trustees, their auxiliary and financing committees, draw community leaders in all large and most small cities. A third of them are under church auspices.

Doctors in areas without community hospitals and city doctors who can't get on community hospital staffs, have set up over 1,000 hospitals. These proprietary hospitals, however, are mostly tiny ones. They include less than 4 per cent of all hospital beds and they are declining as community organization grows; but in some rural sections they still dominate.

This will never be a civilized country until we expend more money for books than we do for chewing-gum.

—Elbert Hubbard, *The Philistine*. Vol. xxv, p. 1.



# MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

## NEWS

### Coming Meetings†

**California Medical Association.** Session will convene in Los Angeles. Headquarters, Hotel Biltmore, 5th and Olive Sts. Dates of meetings: Tuesday, May 7-Friday, May 10, 1946.

**American Medical Association.** The A.M.A. House of Delegates will convene in Chicago, Dec. 3-6, 1945. (See J.A.M.A., Sept. 22, 1945.) In 1946, at San Francisco.

### The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in *CALIFORNIA AND WESTERN MEDICINE* for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576. Also, August, 1945, *CALIFORNIA AND WESTERN MEDICINE*, pp. 61-62.) On p. 61 (*C.M.A.*) and p. 62 (*A.M.A.*)

### Medical Broadcasts\*

**The Los Angeles County Medical Association:**

In November, KFAC will present broadcasts on Saturdays at 10:15 a.m.: November 3, 10, 17 and 24.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

For radio broadcasts of "Doctors at War" by the American Medical Association, see *J.A.M.A.*

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week. In *CALIFORNIA AND WESTERN MEDICINE*, some rosters appear in every second or third issue.

\* County societies giving medical broadcasts are requested to send information as soon as arranged.

### Pharmacological Items of Potential Interest to Clinicians\*:

1. **Bookish:** C. W. Heath & Co. worked hard to describe *What People Are: A Study of Normal Young Men* (Harvard Press, Cambridge, 1945, 141 pp., \$2 and worth it). H. R. Raper's *Man Against Pain; The Epic of Anesthesia* is well, popularly and vigorously written, with merely a few minor inaccuracies and questionable judgments (Prentice-Hall, N. Y., 1945, 337 pp., \$3.50). A. R. Griffin makes hay *Out of Carnage*, retelling medicine's contributions in war (Soskin, N. Y., 1945, 327 pp., \$3). R. Caballero analyses Pasteur's philosophical influence (*Pasteur: Estudio Integral de sus Obras el Hombre, el Filosofo, el Creyente*, Univ. Nac. Litoral, Rosario, 1945, 147 pp.). H. D. W. Smyth's War Dept. report on the atom bomb is now available (*Atomic Energy for Military Purposes*, Princeton Press, 1945, 264 pp., \$2, and full of basic information, so why talk of secrecy?). W. L. Laurence's descriptions of the tests on atom bombing appear serially in *N. Y. Times* beginning Sept. 26, 1945. R. N. Ironside & Co. offer *Aviation Neuro-Psychiatry* (Livingston, Edinburgh, 1945, 176 pp., 8s 6d). M. Sherman discusses *Intelligence and Its Deviations* (Ronald Press, N. Y., 1945, 286 pp., \$3.75). J. M. Hunt writes on *Personality and the Behavior Disorders* (Ronald Press, N. Y., 1945, 2 vols., 1242 pp., \$10). L. du Nouy offers *Studies in Biophysics: Critical Temperature of Serum (56°)* (Reinhold, N. Y., 1945, 183 pp., \$3.50). K. A. Pederson reports *Ultracentrifugal Studies on Serum Fractions* (Almqvist & Wiksells, Upsala, Sweden, 1945, 178 pp., \$2.5). R. Lillie wisely theorizes on *General Biology and Philosophy of Organism* (Univ. Chicago Press, 1945, \$3). I. G. Macy and H. H. Williams cry over *Hidden Hunger: Tragedy of the Unbalanced Diet* (Cattell, Lancaster, 1945, 286 pp., \$3). O. Temkin gives account of *The Falling Sickness: A History of Epilepsy* (Johns Hopkins Press, Balt., 1945, 380 pp., \$4). K. Horney notes *Our Inner Conflicts* (Norton, N. Y., 1945, 250 pp., \$3). H. S. Mustard discusses *Government in Public Health* (Commonwealth, N. Y., 1945, 219 pp., \$1.50). Have you discovered 19 year old Tommy Wadellon, Pfc., and his *Silver Buckles on His Knee* (Coward-McCann, N. Y., 1945), author of *Army Brat, My Father is a Quiet Man*, and *Mother is a Violent Woman*? Then there's Joe Jackson's *Viking Portable Murder Book* (Viking Press, N. Y., 1945, 570 pp., \$2), if you're interested.

2. **Fascistish?** Interesting proposals for Federal support (and control?) of scientific research and education by V. Bush (*Science: The Endless Frontier*, U. S. Govt. Printing Office, Washington, 1945, 184 pp.), L. Chalkley (*Science*, 102:289, Sept. 21, 1945), W. Kaempfert (*N. Y. Times*, July 22 and later), and Senators Magnuson, Kilgore & Co. Is there danger of scientific orthodoxy by continued control of small eastern group of national scientific societies, scientific journals, and now of national funds for support of scientific research and education. For English reaction note editorial on freedom of scientific intercourse (*Nature*, 156:215, Aug. 25, 1945).

3. **Schoolish:** Stimulating symposium on medical education (*Lancet*, 2:225-237, Aug. 25, 1945). J. J. Izquierdo

\* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacological Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

confirms our finding of defects in premedic physics and chemistry training, and gives fine appreciation of W. B. Cannon (*Gac. Med. Mex.*, 75:101, 132, 1945). Some medical students say what they think about medical schools (*J. Asso. Am. Med. Coll.*, 20:296, 1945).

4. *Antibiotish*: G. Lapage reviews recent reports on uses and limitations of penicillin (*Nature*, 156, 244, Aug. 25, 1945). A. L. Barach & Co. find tablespoonful aluminum hydroxide gives practical oral administration of penicillin (*Science*, 102:247, Sept. 7, 1945). J. C. Lewis & Co. find formaldehyde treated gramicidin loses hemolytic and toxic action but not antibiotic (*Ibid.*, p. 274, Sept. 14, 1945). D. Perlstein and A. J. Liebmann announce production of anti-penicillinase immune sera (*Science*, 102:197, Aug. 24, 1945). W. F. Elias & Co. bacteriostatic activity in human sera (*Ibid.*, p. 223, Aug. 31, 1945).

5. *Worthish*: Note symposium on electroshock therapy (*J. Nerv. Ment. Dis.*, 102:221-247, 1945). H. E. Malo-setti describes suboccipital encephalography (*Anal. Fac. Med. Montevideo*, 30:341-526, 1945). L. A. Surraco and J. Lockhart find IV injection of magnesium hyposulfite useful in causalgic symptoms of hot painful foot syndrome (*Ibid.*, p. 293). E. B. Astwood & Co. note reversible motor paralysis after repeated dithiobiuret (*Science*, 102:196, Aug. 24, 1945). D. Nachmansohn and H. M. John find choline acetylating enzyme system in nerve axon and suggest relation to phosphate bond energy and nerve action potential (*Ibid.*, p. 250, Sept. 1, 1945). O. W. Smith and G. V. Smith report a fibrinolytic enzyme in menstruation and pregnancy toxemia (*Ibid.*, p. 253). H. Keil notes biochemistry of Anacardiaceae (*Ibid.*, p. 279, Sept. 14, 1945).

**President-Elect Samuel J. McClendon Addresses Woman's Auxiliary to the San Francisco County Medical Society.**—On Tuesday, November 20th in the Headquarters Building of the San Francisco County Medical Society at 2180 Washington Street, at 1:30 P.M. Doctor Samuel J. McClendon, President-Elect of the California Medical Association, will give an address to the Woman's Auxiliary. His topic will be "General Medical Trends and Legislation." Members of the profession and their families are invited to attend the meeting. Further information may be obtained from the office of the San Francisco County Medical Society, Washington and Laguna Streets, San Francisco, telephone WALnut 6100.

**The American College of Radiology.**—It is tentatively planned to have the next Annual Meeting of the College at the place of the 1946 convention of the American Medical Association, probably on the Sunday prior to the week of the A.M.A. meeting.

The place of the 1946 A.M.A. meeting has not yet been selected. No meeting will be held in 1945. The A.M.A. House of Delegates will meet in Chicago during the week of December 3.

Highlight of the week will be a banquet, to be held in the Grand Ballroom of the Palmer House at 7 P.M. on November 8, under the sponsorship of the Commission on Public Relations. The occasion will commemorate the fiftieth anniversary of the discovery of the x-ray.

President Lowell S. Goin, of Los Angeles, will preside. The principal speaker will be Dr. Robert S. Stone, Professor of Radiology at the University of California and a member of the staff of the University of Chicago which collaborated on the "Manhattan project" in development of the atomic bomb. Doctor Stone will speak on "Radiology, From Roentgen to the Era of Atomic Energy."

**West Virginia State Medical Association.**—The seventy-ninth annual meeting of the West Virginia State Medical Association will be held at the Hotel Prichard in Huntington, West Virginia, May 13-14-15, 1946.

(The next annual session of the California Medical Association will be held in Los Angeles commencing Tuesday, May 7, 1945 through Friday, May 10th. A four day session. Headquarters will be at Hotel Biltmore.)

**Plutonium Research Hinged on Cyclotron.**—Lack of a large cyclotron, such as the one on the Berkeley campus of the University of California, may have been the factor which thwarted German scientists in their search for the secret of harnessing atomic energy.

This is the statement of Dr. Charles D. Coryell, associate professor of chemistry on the Los Angeles campus of the University of California, who has been working on the atomic bomb project at Chicago and Oak Ridge, Tennessee, since May, 1942.

Speaking at a University seminar, Dr. Coryell pointed out that the large cyclotron made possible certain studies of plutonium, the material eventually employed in the bomb dropped on Nagasaki.

**Men Get Tired—But Science Keeps Them Going.**—Experiments involving volunteer "human guinea pigs," including a 112-hour "insomniathon" last July, have successfully minimized the fatigue of sleeplessness and seasickness of combat troops, the California Institute of Technology recently disclosed.

Dr. David B. Tyler, Professor of Physiology who directed the tests, said military censorship still prevented disclosure of the techniques by which scientists were able to keep soldiers awake through long periods of combat.

Nationwide attention was focused on the project last July when a dozen drooping conscientious objectors stayed awake for five consecutive days. They underwent constant physiological, psychological, and chemical tests on the effects of fatigue.—*San Francisco Chronicle*, October 29.

**Malpractice Insurance Rates for Radiologists Increased.**—While negotiations were in progress between the American College of Radiologists and a large American insurance company for a special blanket malpractice policy for Members and Fellows of the College, news was received last week of a sharp increase in premiums for the Lloyd's of London policy now held by a large number of College members. Varying in designated states, premiums for \$25,000/\$75,000 limits were raised from a fraction to more than 200 per cent in some states on renewals after October 1.

Pending the execution of a blanket policy with the company with which negotiations were being held, members were advised to consult local agents concerning protection in the event they hold Lloyd's policies which expire during the next six months.

Established companies now give adequate coverage for radiologists at reasonable rates in a few states, such as Pennsylvania, New York, and Maryland. In others, rates have been almost prohibitive except under the Lloyd's agreement, and in certain western states, even Lloyd's has charged more than \$300 for \$25,000/\$75,000 limits. Now the Lloyd's premiums are being increased throughout North America.

**Uranium.**—Prominent among the famous group of German apothecaries whose work led to the identification of many of the elements was Martin Heinrich Klaproth (1743-1817), discoverer of uranium. According to the



*History of Pharmacy*, by Kremers and Urdang (J. B. Lippincott), Klaproth was outstanding even in this gifted group. His discoveries were not accidental but due to his extraordinary skill in analysis, both qualitative and quantitative. Besides uranium, Klaproth is credited with the discovery of zirconium and cerium, and with verification of the elemental character of tellurium, strontium, titanium, chromium and yttrium. Most of Klaproth's work was done in a small laboratory in his own pharmacy.

**Press Clippings.**—Some news items from the daily press on matters related to medical practice follow:

#### California Institutions Housing 5,944 Excess Patients

Sacramento, Oct. 15.—(AP.)—California's institutions for the insane, mentally defective and blind have an excess population above normal capacity of 5,944 persons, an overcrowding of nearly 25 per cent, Director Dora Shaw Heffner, of the Department of Institutions, reported today.—*San Francisco Chronicle*, October 16.

#### Another "Day" Proposed

As if the calendar were not already heavily enough overloaded with special "days" dedicated to exhortations for people to eat more bread, wear bigger and better straw hats, add vitamin pills to the diet and do their washing with this or that brand of soap, a move is afoot to establish "officially" another special day. And what a day! A Senate joint resolution would authorize and request the President "to issue a proclamation designating the 31st day of October of each year as National Arthritis Day."

We presume the purpose is to focus universal attention intensively on that disease on a designated day in the hope that greater gains could be made in preventing and curing that particular malady. And if the plan could be effective in overcoming that affliction, the logical procedure would be to dedicate a special day for similar concentration on every other disease. The result would be a bumper crop of hypochondriacs.

By all means, research by qualified experts should continue in the effort to curb arthritis, as well as all other maladies that add to human suffering. But such research can be carried on quite as well without nationwide concentration on it once a year as it could if the public were to take such an officially proclaimed day seriously.

It will be recalled that a few years ago the medical profession itself established unofficially a Cancer Week in which all of us were supposed to give thought to the causes and symptoms of cancer and determine whether we were personally endangered. We cannot say whether there were any real cancers prevented by that promotional process, but we do know that thousands of imaginary ones were created by it.

The medicos soon dropped their Cancer Week plan.—*Burlingame Advance*, October 8.

#### Dr. Robert A. Peers, Resigned Mayor of Colfax Is Banqueted

Colfax (Placer Co.), Oct. 8.—Dr. Robert A. Peers, who resigned in July as mayor of Colfax, was the honored guest at a banquet held here last night attended by members of the city council, the Placer County Defense Council and other city and county officials.

The former mayor, who served on the city council for nearly 24 years, was presented with an embossed resolution by his former associates. Judge Lowell L. Sparks, in behalf of the defense council, of which Dr. Peers also was a member, presented him with a gift.—*Sacramento Bee*, October 8.

#### Alcoholism Is Called U. S. Health Threat

Chicago, Oct. 4.—(AP.)—Two medical writers declared today that "alcoholism in America is a serious national health problem," estimating that there are 600,000 chronic alcoholic addicts, 2,000,000 heavy drinkers and 38,000,000 "social drinkers."

Dr. Robert V. Seliger, psychiatrist at Johns Hopkins Hospital, Baltimore, and Victoria Cranford, psychotherapist at a Cantonsville, Md., sanatorium, reported in the *Journal of the American Medical Association*:

We understand the effects of our national expansion, restlessness, heterogeneity, industrialism and historical growth on the incidence of alcoholism to be enormous, owing to mass and individual insecurity and change in

nearly all spheres of life plus quantity and quality of mobile living . . .

Mental illness, juvenile delinquency and criminality are, like alcoholism, partly derived from environmental situations, and also, like alcoholism, they are on the increase. Society must assume its responsibilities on a realistic basis to help provide environments that do not tend to produce retarded or warped personalities.—*Sacramento Bee*, October 4.

#### Modern Midwife

Nurse midwives deliver about 1,200 babies each year in the United States. Graduate nurses with two years' professional nursing experience, they still are comparatively new among the thousands of licensed midwives in this country. Another 250,000 American babies a year are born with the aid of unlicensed midwives, who know all about old superstitions but little of modern hygiene. Of America's yearly baby crop, 8.1 per cent get their post-natal spank from midwives. The southern states have the greatest number. The nurse midwife cooperates closely with a doctor, and usually delivers a baby only when a doctor is unavailable.—*San Francisco Chronicle*, October 25.

#### Strike Snags Medical Journal

Chicago, Oct. 11.—(AP.)—For the first time in 62 years the *Weekly Journal of the American Medical Association* was not circulated today because of a Chicago commercial compositors' strike.

The Association said it was notifying its 110,000 subscribers that back issues containing material intended for publication during the strike would be issued when the walkout has ended. The *Journal* serves as an exchange of scientific information among members of the medical profession.—*Los Angeles Herald and Express*, October 11.

#### State Medicine Deemed Remote In California by Physicians

("Christian Science Monitor").—The California Medical Association assumes that enactment of compulsory health insurance, which it vigorously opposed, has been warded off here for the immediate future, though government insurance for medical care has been pushed harder in California than in any other state.

The Association believes that its own declaration of principles on this controversial question, plus its own voluntary medical insurance plan known as the California Physicians' Service, will provide ample safeguards against possible revival of the issue in this State.

The Association successfully combated two bills which came before the Legislature this year, and won both points by basing its attack on the assertion that regimentation of the public and of the medical doctors was proposed under a system of State medicine.

The statement of principles adopted recently by the Council of the Association listed affirmatively the grounds for the Association's opposition.

A primary consideration in any system of budgeted medical care, the Council asserted, must be that there shall be no deterioration in the quality of medical service.

Another point is that any system of medical care should be voluntary and not compulsory in nature.

The medical doctors had the help of many groups, likewise opposed to compulsory medical insurance, when they opposed the two proposed measures before the State Legislature this year.

"Any sound health insurance program," the Council of the Medical Association sets forth, "should fully protect freedom of choice, both of the patient in choosing a physician and of the physician in choosing his community, type of practice, and professional procedures."

The function of the State, rather than to compel universal health insurance, the Council holds, should be to encourage voluntary health insurance programs such as its California Physicians' Service, and "not regiment the patient and the medical profession or operate compulsory health insurance plans established by political means."

The Council of the Association recommends a coordinated program on the part of all groups concerned with the problem of health or medical insurance. The Association's speakers frequently have paid their respects to the religious organizations and veterans' bodies which opposed the proposed compulsory legislation on quite other grounds from those advanced by the medical profession.

"The sanctity of the patient-physician relationship must be maintained," also says the statement of principles, "and the method of providing medical care must not become enmeshed in bureaucratic red tape and a system of

tickets, coupons, questionnaires, and other political controls and delays."

The California Medical Association is a voluntary Association composed of 7,827 doctors of medicine in California, or about 85 per cent of the licensed and practicing physicians of the State.

In 1939 it established the California Physicians' Service to supply a prepayment method for insuring against excessive costs of medical care for the low-income groups.

The Service now enrolls about 175,000 subscribers, according to Dr. Lowell S. Goin, immediate Past President of the Association, who was head of the organization and active spokesman for it during the legislative contest which continued for several months while the State Legislature was in session this Spring.

According to Dr. Goin, the Physicians' Service at present is enrolling about 10,000 new members each month. He expects that the entire membership of the California Grange, some 80,000 persons, will be enrolled for the voluntary medical insurance plan before long.

There is no need today for any degree of compulsion in the matter of health insurance, if there ever was, the Medical Association holds. Any such need as may have existed, say its spokesmen, is diminishing rather than increasing.

Dr. Goin, addressing the Medical Association with a farewell paper at the close of his term as President, said: "Compulsory health insurance is an integral part of a social philosophy which looks to the submerging of personal freedom in an all-powerful state."—*Christian Science Monitor*, October 1, 1945.

### DDT

As an insecticide DDT (Dichloro Diphenyl Trichloroethane) is especially useful in combating bedbugs, mosquitoes, fleas, lice, houseflies, and certain agriculturally important pest insects. Conflicting results have been obtained on its efficacy against certain species of ants (although effective against some), cockroaches, spiders, and ticks. It has no value when used against the chigger or poultry mite.

The action of DDT on insects is slow but sure. It is usually several hours before it causes death in the mosquito or housefly and 48 hours or longer in the bedbug. DDT is an insect repellent but is rather a strongly toxic agent. Its lasting effectiveness is dependent upon the persistent clinging of the chemical to a surface after the solvent has evaporated.

A 5 per cent solution sprayed on screens, walls, ceilings, beds, and mattresses, if not washed off, will effectively destroy flies, bedbugs and mosquitoes for several months.

DDT powder, 10-20 per cent in talc can be applied to the sleeping places of dogs and cats and to the fur of dogs to eliminate fleas. There is some danger in applying DDT to the fur of cats due to their custom of licking themselves. A water miscible powder 20 per cent (1½ lb. per gal.) is effective when sprayed around chicken houses, horse stables, etc.

In California DDT is considered and treated the same as any other new economic poison, and all the provisions of the Economic Poisons Article of the Agricultural Code apply. Labels must bear proper statement of ingredients and adequate directions for use including any necessary cautions.

Pending development of information to the contrary, products containing DDT more than 1 per cent sold in California must carry the skull and cross-bones and the word "Poison" printed in red on white background, or vice-versa, and antidote as follows:

Antidote: Call physician immediately. External—wash with soap and water. Internal—emetic of mustard.

The next issue of the *Bulletin* will consider the toxicity of DDT.—*Weekly Bulletin* of the Department of Health, City of Los Angeles.

### DDT Toxicity

Studies on the toxicity and potential dangers of DDT are in progress and the final word is not yet available. It seems evident that it is a relatively non-toxic substance when used with reasonable care.

Toxicity experiments on animals reveal clinical evidence of central nervous system irritation, with tremors, irritability, depression, and convulsions. Histopathologic studies in animals have shown a moderate subacute degeneration of the liver.

Evidence seems to point to the various DDT solvents as being at time more toxic than the DDT itself. The inhalation of heavy concentrations of fine mists of kerosene or cyclohexanone (used as solvents) may cause irritation of the eyes and upper respiratory tract, headache, and loss

of equilibrium. Chlorinated hydrocarbons should not be used as solvents. Solution of DDT in fatty oils increases its toxicity to animals. Irritation of skin may result from heavy exposure due to the fat solvent properties of petroleum distillates.

Even though our knowledge of the toxic effects of DDT is, as yet, not complete, the health department feels that it should call attention at least to the following facts:

1. DDT is tasteless, and in powdered form, especially when mixed with talcum powder, it bears a physical resemblance to flour. It must not, therefore, be stored along with food supplies.

2. In spraying, care should be taken to cover food and household utensils.

3. Many sprays containing DDT have a petroleum base solvent. Do not spray, therefore, near an open flame.

4. Do not spray near fish bowls nor birds.

5. Petroleum oil base products containing DDT (such as kerosene) may injure animals if sprayed on them. Powder containing DDT may be used for control of fleas and lice on dogs and certain other animals. It would appear, however, that such products should not be used on cats because of their tendency to lick themselves.

6. Care should be taken to avoid long-term, heavy exposure to skin or respiratory tract, especially when a kerosene solvent is used. There is some evidence that long-term, heavy exposure to DDT itself may be cumulative.

7. Allergic manifestations such as rash may occur in some individuals, due either to the solvent or DDT itself. —*Weekly Bulletin* of the Department of Health, City of Los Angeles.

### Doctor Strike in Argentina

Buenos Aires, Oct. 8.—(AP.)—The wave of unrest against the Argentine military government threatened to spread to the medical profession tonight with members of the Argentine Medical Association announcing a general strike of doctors "already had been declared in principle."

The strike, Association members said, "can be ordered at any moment."

If the general strike is called, Association members reported, doctors will refuse to diagnose, prescribe or operate except when necessary to save a life.

Members of the Association said dentists and druggists were joining the movement. . . .—*San Francisco Examiner*, October 9.

### Doctor Stanley Will Assume San Quentin Post

Warden Clinton T. Duffy of San Quentin yesterday announced that Captain Leo L. Stanley, USNR, chief surgeon at the prison before entering the Navy in January, 1942, will return to his former post December 15.

The doctor spent three years in the Pacific, part of the time as head of the Pearl Harbor Naval Hospital. Dr. Alex Miller of the prison's medical staff has been acting chief surgeon during Dr. Stanley's absence.—*San Francisco Chronicle*, October 29.

### Fifty San Quentin Convicts Again Guinea Pigs for Plague Tests

A second series of experimental inoculations of San Quentin Prison inmates—who volunteered as "guinea pigs" for tests of a new vaccine for use against bubonic plague—were begun on October 2, it was disclosed by Warden Duffy's office recently.

The first series of tests, last June 4, involved 50 volunteers secured through the prison paper and over the Grey Network, the San Quentin radio. The inoculations were made by Dr. Karl Frederick Meyer, using a vaccine produced by the Hooper Foundation of the University of California.

Dr. Meyer said today that his experiments are still classified as a top military secret, so he could give out no details about them. He indicated, however, that many "interesting new things" are being learned about the control of bubonic plague through them.

The second series of tests also involves 50 San Quentin volunteers. They were chosen from a list which, according to prison sources, "swamped" Neumiller Hospital.

"San Quentin has never failed to supply men for this type of experiment," said Warden Duffy.

The research work on the vaccine has been carried on by Dr. Meyer since January 3, 1942.

Bubonic plague germs are carried by ground squirrels in the Western States and by rats in the Bay Area. Rat control has been of primary importance with the U. S. Health Service and local health departments because of this fact.



The last human case of bubonic plague in California was reported in 1943.—San Francisco News, October 18.

#### Sister Kenny in L. A. to Aid Film

Los Angeles, Oct. 28.—(INS.)—Sister Elizabeth Kenny, famed for her successful treatment of infantile paralysis, arrived in Los Angeles today for final conferences on the filming of her life story.

The famed Australian nurse was greeted at the airport by actress Rosalind Russell, who plays the title rôle in "The Life of Elizabeth Kenny," and Dudley Nichols, who wrote the script and will produce and direct it. The film goes into production about November 5, at RKO.—San Francisco Examiner, October 29.

#### Health Insurance Plan Is Osteopaths' Topic

A meeting of the Fresno County Osteopathic Society to discuss means of providing increased medical and hospital care through some compulsory health insurance plan will be held tomorrow at 8 P.M. in the office of Dr. Lynn W. Fawns in the T. W. Patterson Building, with Thomas C. Schumacher, executive secretary of the California Osteopathic Association, as the principal speaker.—Fresno Bee, September 27.

## MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.

San Francisco

### Hospitals: Liability for Injuries Sustained by Patient Falling or Jumping Through a Window

A private hospital under established precedents is required to exercise such reasonable care toward a patient as his known condition may require; and by a recent decision of the California Supreme Court it was held that this duty extends to protecting the patient from self-inflicted injuries, either intentional or unintentional.

In *Wood vs. Samaritan Institution*, 26 A.C.A. 782 (August 31, 1945), the plaintiff brought suit against the Samaritan Institution, a private sanitarium, for injuries sustained when she fell or jumped from a second story window of the sanitarium while entered as a patient to receive treatment for alcoholism.

Before the trial court, the testimony was substantially as follows: For several years plaintiff had been addicted to excessive use of intoxicating liquor and on January 5, 1943, she entered the defendant's sanitarium for treatment. A practical nurse who was on duty in the sanitarium at the time plaintiff entered, testified that plaintiff seemed drowsy and highly nervous and stated that she was afraid she was in an insane asylum. These facts were reported to the nurses in charge and later the practical nurse found plaintiff purportedly scrubbing her floor at home. This was also reported to the nurses in charge. The physician employed by the sanitarium administered certain drugs to plaintiff and on January 6, 1943, ordered sedatives and "physical restraint as required." There were three large windows in plaintiff's room with double screens which could be pushed out in the center. There was no nurse on duty in plaintiff's room and she was not subjected to any restraint. On January 7, 1943, she was found lying on the cement courtyard beneath the window of her second story room suffering from the injuries for which she sought damages from the defendant in this action.

The trial court had granted the defendant's motion for a non-suit at the conclusion of the plaintiff's case which included the testimony outlined above, the court concluded

that there was not sufficient evidence to allow the jury to pass on the defendant's liability. The trial court ruled that, as a matter of law, the defendant was not liable under facts shown. On appeal to the State Supreme Court, this judgment was reversed, the higher court holding that the matter should have been submitted to the jury as plaintiff's case contained sufficient evidence to justify a finding that the defendant sanitarium had violated its duty to plaintiff to exercise reasonable care.

The Supreme Court quoted the following rule from *Corpus Juris Secundum*: "A private hospital owes its patients the duty of protection, and must exercise such reasonable care toward a patient as his known condition may require. The measure of duty of a hospital is to exercise that degree of care, skill and diligence used by hospitals generally in that community, and required by the express or implied contract of the undertaking. A hospital is liable for want of ordinary care, whether from incompetency of a nurse or failure in duty by a fully qualified nurse. . . . The duty of care imposed on a hospital extends to safeguarding the patient from dangers due to mental incapacity. . . . On the other hand, a private hospital is not an insurer of a patient's safety, and the rules as to care required are limited by the rule that no one is required to guard against or take measures to avert that which a reasonable person under the circumstances would not anticipate as likely to happen."

In this case it was a question for the jury to decide whether in failing to place plaintiff in some form of physical restraint after notice of plaintiff's actions, the sanitarium had breached the standard of care required of hospitals in such cases.

The Supreme Court pronounced the rule that where "plaintiff's evidence establishes that the means of harm were at hand (existent in the physical surroundings) and that defendant had notice or knowledge of facts from which it might be reasonably concluded that a patient would be likely to harm himself or others unless preclusive measures were taken, then defendant must use reasonable care in the circumstances to prevent such harm."

### Oleomargarine

With the advent of war there has been a considerable decrease in edible fats available for civilian consumption. As a means for increasing the supply of solid edible fat to replace the decreasing amount of butter available for nonmilitary populations, margarine has been increasingly emphasized. Aside from the fact that this food has been fortified to the extent of 9,000 international units of vitamin A per pound to compensate for its lack of this vitamin, much discussion has concerned the nutritional value of fortified margarine as compared with butter fat. Various economic interests have been injected into this discussion, but only recently has objective evidence on the nutritional value of this fat been available. . . .

Deuel and his associates studied the effect of different fats on fertility and lactation, since under these circumstances the dietary requirements constitute a more stringent test of nutritional adequacy than does growth. . . .

The experimentalists in nutrition have shown that margarine may be substituted for butter fat with impunity in regard to growth, reproduction and lactation, provided the diet is nutritionally adequate. Of all the fat soluble vitamins, margarine is deficient in vitamin A, but this deficiency is made up by the fortification of the product with added vitamin A. This is a common procedure and most products on the market today are fortified in this way. The possibility of using margarine as a low cost fat may be of considerable importance in the feeding of the war seared population of Europe; it may also be used with safety in this country when a less costly edible fat is needed.—Editorial in *J.A.M.A.*, July 21, 1945.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

## TWENTY-FIVE YEARS AGO†

### EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 11, November, 1920

#### EXCERPTS FROM EDITORIAL NOTES

*Individualism in Medicine.*—The recent campaign involving the anti-health measures, brought out clearly certain types of medical minds. No properly informed person had any doubts concerning the pernicious character of the first three proposed amendments and the propriety of the last, but they reacted in different ways.

To those who threw their energies into the effort to protect human life and promote social betterment in this issue, we owe our thanks.

There are those, however, who assumed an attitude of non-resistance. Their belief is that the public has a perfect right to go unvaccinated if it choose so to do. That it will learn through experience the folly of its ways. They hold that a man who employs an uneducated and unsafe vender of cures takes his chances, and deserves what poor treatment he gets. . . .

*Malpractice—Indemnity Defense Fund.*—Some of our members apparently are still ignorant of the benefits and advantages which they enjoy or may secure by reason of their membership, particularly those relating to protection from malpractice claims and actions. For their benefit we summarize here some of the basic facts.

Any member who in the year 1920 keeps his dues fully paid in his County Society and the State Society, is thereby entitled in a meritorious case to the services of the Society's Legal Department in protecting him from an unfounded malpractice claim or suit. This, of course, should the court or jury rule against him, does not provide for the payment of such an adverse judgment.

*Council of Social and Health Agencies.*—There has just been formed in San Francisco a Council of Social and Health Agencies, which is designed to function as a clearing house for the relief and social problems of the city, and which should bear the same relation to municipal affairs that the State Conference of Social Agencies bears to State affairs. The objects of such a Council are (a) the promotion of real coöperation among all the public and private health and social agencies, (b) the development of higher standards and the promotion of greater efficiency in social and health work, (c) the prevention of waste and duplication of effort, (d) to advise in the undertaking of new work by organizations already in existence and in the creation of new agencies, (e) the promotion of all necessary activities and the discouragement of all unnecessary ones.

#### EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

*From an Article on "Nasal Plastic Surgery," by H. B. Graham, M.D., San Francisco.*—No one surgical procedure is sufficient for any one pathological condition. Therefore, the more familiar a surgeon is with the various methods employed to gain a given result, the better (Continued in Front Advertising Section, on Page 20)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members. Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco 8.

## BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.

Secretary-Treasurer

### Board Proceedings

The Board of Medical Examiners held its Annual Meeting in Sacramento, October 15 to 18, 1945. At this meeting written examinations were conducted for the various groups under jurisdiction of the Board, petitions for restoration of revoked licenses were considered and legal hearings for the revocation of licenses were held.

### News

"The Irwin Memorial Blood Bank at 2180 Washington Street (San Francisco) yesterday completed its program of expansion and invited wartime donors to continue their gifts of blood. With discontinuance of the wartime emergency Red Cross Blood Procurement Center, the Irwin Blood Bank will be the Bay Area's chief source of whole blood, Dr. Curtis E. Smith, chairman of the blood commission of the County Medical Society, said. . ." (San Francisco Chronicle, Sept. 20, 1945.)

"If a physician calls in a consulting physician without first consulting the patient about it, then the patient does not have to pay the second doctor. This opinion, reversing a judgment of Municipal Judge Ida May Adams, was handed down by Judges Hartley Shaw, Clarence L. Kincaid and Edward T. Bishop of the Appellate Department of Superior Court. In the case Dr. Donald Cass was given a judgment of \$100 against Jose Eymil, who contended he had never heard of the medical man until he received a bill from him. Dr. Cass charged that he had been consulted by Eymil's attending physician." (Los Angeles Times, Sept. 24, 1945.)

"Dr. Rudolph von Urban, Monterey county's outspoken exponent of sex education and an authority on connubial bliss, who claims American men are inexperienced lovers, lost his job yesterday as county psychologist. Members of the Board of Supervisors, who declared they are frantic from complaints by taxpayers who resent Dr. von Urban's sex talks before service clubs, declined to reappoint him. . . . Dr. von Urban, one-time associate of Freud, was the central figure two years ago in a battle instituted by an investigator for the State Medical Board who claimed the Viennese specialist was practicing medicine without a license. Dr. von Urban won the case." (San Francisco Chronicle, Sept. 27, 1945, from Salinas press dispatch dated Sept. 26, 1945.)

"A safe containing \$300,000 in cash was found by police at the Guerrero Street home of Inez Burns, 57, released on \$1,000 bail last night after her arrest on charges of suspicion of abortion. An elaborate suite, including three operating rooms, alleged to have been headquarters of an abortion mill operated by Mrs. Burns, also was raided by police late yesterday. The suite, located at 325-7 Fillmore Street, has been raided three times in the past ten years and in each case Mrs. Burns, also known as Inez L. Brown, was implicated. In 1936 she was declared the owner of \$2,000 worth of property (Continued in Front Advertising Section, on Page 24)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.





**Stimulative  
Therapy in  
Reproductive  
System  
Dysfunction**

# GONADOPHYSIN

Zondek has summed up the influence of the anterior pituitary upon sex functions in these words:

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Where supplementation of deficient anterior pituitary follicle stimulating and luteinizing hormones is indicated, Gonadophysin presents these fractions prepared from fresh sheep glands in stable powder form. Solution for injection is easily and quickly prepared by adding the sterile diluting solution which accompanies each ampul.

Gonadophysin is being used with definite therapeutic effect in developmental disturbances of the reproductive system resulting from gonadotropic hormone deficiency, the management of menstrual disorders referable to ovarian dysfunction, and in functional menopausal states.

**Supplied in packages of three serum-type ampuls (500 Rat Units each) and three 5 cc. ampuls of dissolving solution.**

*Gonadophysin is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois*

\*Synopsis of Materia Medica, Toxicology, and Pharmacology, Davison, F. R.: Hormones, St. Louis, The C. V. Mosby Company, 1942, p. 582.

# SEARLE

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Building)

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Long Beach: Thackray's Prescription Phar-  
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Merced: Maze Drug Store

Modesto: Thorne's Prescription Pharmacy

Oakland: Peralta Hospital Pharmacy

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Exclusive Prescription Pharmacy

Sacramento: Pucci's Professional Pharmacy

Salinas: Holaday's Pharmacy

San Francisco: Lane Prescription Pharmacy,  
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San Jose: Columbia Pharmacy  
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The Surplus Property Division of the Reconstruction Finance Corporation offers pathologists opportunity to purchase hemotoxylin crystals packaged in 10 gram bottles and priced at \$1.50 per bottle in quantities up to 1900 grams. For orders of 2000 grams or more, the RFC will sell 10 gram bottles at \$1.00 per bottle.

The National Institute of Health Pathological Laboratory reports the crystals in excellent condition, and orders to purchase can be placed through the San Francisco RFC Agency office, 200 Bush Street, San Francisco 4, California.

### Public Opinion on Health

Summarizing some of the public polls on health conducted by his organization, George Gallup in the July-August, 1945, issue of Channels underlines Raymond Clapper's statement:

"Never overestimate the people's knowledge, nor underestimate their intelligence."

In 1936, when newspapers and radios were afraid to mention venereal diseases, a Gallup poll revealed that 90 per cent of the people were in favor of starting an educational program and 88 per cent were in favor of establishing governmental VD clinics.

In 1937, seven out of 10 people believed that the dissemination of birth control information should be made legal. Today, public sentiment stands 7-3 in favor of making birth control information available through public health clinics.

Public sentiment is 4-1 in favor of having sex hygiene taught in secondary schools.

Gallup polls have revealed that the people don't know as much as they should about the cause and prevention of disease, nor about diet.

(Continued on Page 38)



# AT HOME OR AWAY

## SPOT TESTS

# SIMPLIFY URINALYSIS

### NO TEST TUBES • NO MEASURING • NO BOILING

Diabetics welcome "Spot Tests" (ready to use dry reagents), because of the ease and simplicity in using. No test tubes, no boiling, no measuring; just a little powder, a little urine—color reaction occurs at once if sugar or acetone is present.

### *Galatest*

FOR DETECTION OF SUGAR IN THE URINE

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FOR DETECTION OF ACETONE IN THE URINE

### THE SAME SIMPLE TECHNIQUE FOR BOTH

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A carrying case containing one vial of Acetone Test (Denco) and one vial of Galatest is now available. This is very convenient for the medical bag or for the diabetic patient. The case also contains a medicine dropper and a Galatest color chart. This handy kit or refills of Acetone Test (Denco) and Galatest are obtainable at all prescription pharmacies and surgical supply houses.

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Spencer Supports designed for men are masculine  
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For a dealer in Spencer Supports, look in telephone  
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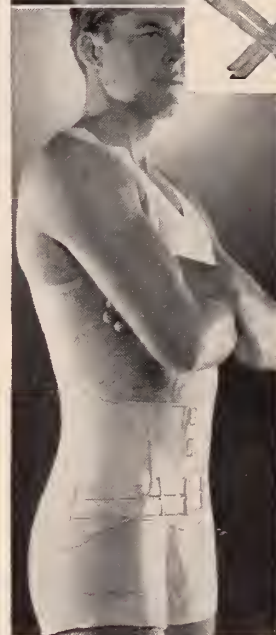
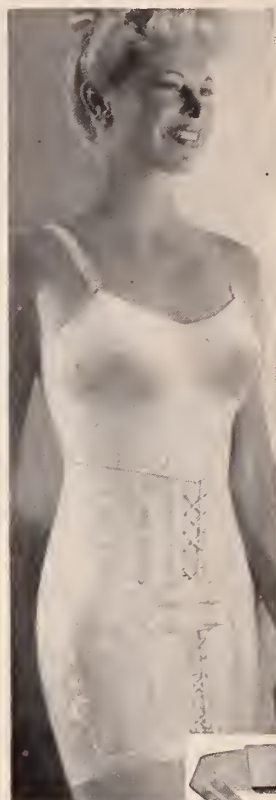
Instability in sacroiliac and lumbosacral areas is effectively checked by a Spencer Support designed to grip pelvis, and provide coordinated abdominal and back support. Thus posture is improved.

#### *Pelvic Band Aids in Inhibiting Movement*

A simple pelvic band is incorporated in the support. The band encircles the pelvic girdle *inside* the support and is instantly adjustable from *outside* the support to any degree of snugness required. When the condition subsides, the band may be removed and the remainder of the support worn as a safeguard against recurrence of acute symptoms.

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Each Spencer Support is individually designed, cut and made at our New Haven Plant *after* a description of the patient's body and posture has been recorded—and 15 or more measurements have been taken. This assures the doctor that each patient will receive the proper design to aid his treatment; that the support will improve body mechanics and will fit with the precision and comfort necessary. Yet a Spencer costs little or no more than an ordinary support.



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'DELVINAL' sodium vinbarbital will provide  
a relatively brief induction period and a  
moderate duration of action. Undesirable  
side-effects such as excitation or  
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Council accepted. Supplied in  $\frac{1}{2}$  gr.,  
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*Sodium Vinbarbital*



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# USE INJECTABLE VITAMINS B-PLEX IN 30cc. VIALS

THIAMINE HYDROCHLORIDE	50. mgm.
RIBOFLAVIN	0.5 mgm.
PYRIDOXINE HYDROCHLORIDE	2. mgm.
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NICOTINAMIDE (*)	50. mgm.

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## PUBLIC OPINION ON HEALTH

(Continued from Page 34)

Twenty-one per cent of the people think cancer is contagious. Many people think it is caused by swallowing phlegm, by using certain kinds of cooking pots, by jealousy, resentment or "bad thoughts."

One out of every four persons is unaware of the fact that tuberculosis is contagious.

From 23 to 46 per cent of the people fail to eat a well balanced diet, mostly because of ignorance.

### Remove Boric Acid From Use Entirely, Pediatrician Says

*Claims Poisonous Drug Should Be Taken Off Hospital Shelves and Replaced By More Effective Germicides*

Boric acid, which has caused the accidental deaths of several infants during the last few years, should be removed from use entirely, says E. H. Watson, M.D., of Ann Arbor, Mich., in the September 29 issue of the *Journal of the American Medical Association*.

Dr. Watson, who is connected with the Department of Pediatrics and Communicable Diseases at the University of Michigan Medical School, believes that boric acid has been superseded today by more effective germicides and preparations.

Urging doctors to discourage the use of boric acid because of its limited usefulness, Dr. Watson says:

"It cannot sensibly be argued that an effective drug should be dropped from use simply because the occasional patient reacts unfavorably to the ordinary dose or because untoward reactions follow the accidental administration of an excessive dose. When, however, a drug can be shown to be almost entirely ineffective and at the same

time dangerous even when used in ordinary ways, it is time to remove that drug from general use as rapidly as possible. Boric acid is such a drug."

From time to time in the past, boric acid administered in milk formulas caused the deaths of numerous babies. . .

"As long as there are human beings handling devices or drugs of possible danger, accidents will occur. . . . Boric acid is so frequently used as a household article that its power for harm is ordinarily overlooked. Yet its potential danger is such that its use as a food preservative has long been forbidden in the United States, France, Germany, Holland, Italy and Spain."

Dr. Watson states that boric acid preparations were removed from use in the children's ward of University Hospital several years ago. . . .

After pointing out that boric acid is a very weak germicide, Dr. Watson says: "The medical profession as a whole probably puts unwarranted confidence in boric acid preparations and is likely to forget that boric acid is a poison."

### Optometry Refresher Courses Announced by U. C.

In response to requests from its graduates and many other licensed optometrists, the School of Optometry on the Berkeley campus of the University of California will offer refresher courses of an intensive type to be given through the University Extension Division. The announcement comes from Dr. R. S. Minor, dean of the School, who says that instruction will be offered in clinical practice, instrumentation, orthoptic training, office organization and management, and theory and fitting of contact lenses. Each course will be for thirty hours to be given during a six weeks period. Dates and time will be announced later.

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No  
appreciable  
ciliary  
inhibition...

Benzedrine Inhaler causes  
“no appreciable change in the amplitude or rapidity of  
the ciliary beat.”

Proetz, A.W.: Arch. Otolaryng., 30:509.



In addition, Benzedrine Inhaler, N. N. R., does not give rise to any significant degree of secondary turgescence, atony or bogginess, when used as directed.

The Inhaler is strikingly effective in reducing the congestion accompanying head colds, hay fever, and sinusitis. Each Benzedrine Inhaler is packed with racemic amphetamine, S. K. F., 200 mg.; menthol, 10 mg.; and aromatics. Smith, Kline & French Laboratories, Phila., Pa.

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Inhaler

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better means of  
nasal  
medication



# Effective Convenient Economical

THE effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use. For professional convenience Mercurochrome is supplied in four forms—Aqueous Solution in Applicator Bottles for the treatment of minor wounds, Surgical Solution for preoperative skin disinfection, Tablets and Powder from which solutions of any desired concentration may readily be prepared.

## Mercurochrome

(H. W. & D. brand of merbromin, dibromoxymercurofluorescein-sodium)

is economical because stock solutions may be dispensed quickly and at low cost. Stock solutions keep indefinitely.

Mercurochrome is antiseptic and relatively non-irritating and non-toxic in wounds.

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**T**HE new light became visible like a dazzling meteor in the evening of the nineteenth century. It surrounded the morning of our own century with the rosy light of hope and promise. Like a glittering sun it shines resplendent on the working day of the twentieth century, revealing new fairways and fresh horizons in nearly every land in the world of science. . . . In commemorating William Conrad Roentgen this year—the centennial of his birth, also the semi-centennial of his discovery of the x-ray—one is inspired anew by the above tribute spoken by Dr. Gosta Forssell, of Stockholm, Sweden, before the Fifth International Congress of Radiology, held in Chicago in 1937.

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## Anton Chekov: Author and Physician

Had Anton Chekhov been possessed of normal health he might have become one of those rare men who distinguish themselves simultaneously in two professions. In his comparatively short life of 44 years he achieved a reputation as one of the greatest of Russian writers; but he was also a physician who continued to practice medicine until the ravages of tuberculosis made this impossible. He possessed many qualities which should have been valuable in medical practice: a capacity for accurate observation, an objective and logical approach to any problem which confronted him, and a sympathetic and humane nature. Physicians who had been present at consultations with him said that he had remarkable ability as a diagnostician. It was his desire to carry on his work in both his chosen fields.

Chekhov himself once wrote: "I have two professions

and not one. Medicine is my lawful wife and literature my mistress."

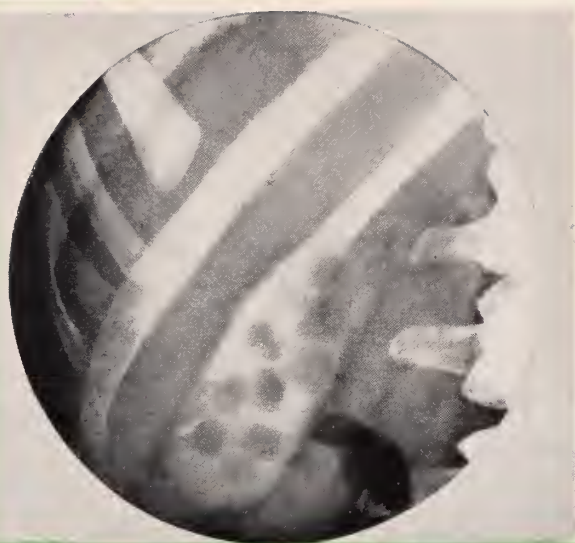
## Favoritism

"That socialized medicine is not good for the country was clearly proved during the depression, when Emergency Medical Relief was organized as an embryonic government agency," declared Dr. Samuel Barbash, editor of the Atlantic County (N.J.) Medical Society *Bulletin*, in a recent "guest editorial" written for the Jackson County (Mo.) Medical Society *Bulletin*. "Its ideals and purposes were endorsed by every earnest practitioner who recognized the need it was trying to fill. However, political favoritism and miscarriage of aims were not only discouraging but disgusting. It is appalling to contemplate the same experience on a national scale."

—San Francisco *Western Underwriter*, August.

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1. Hefke, H. W.: Radiology 42:233, 1944.

2. Bryan, L., and Pedersen, N. S.: Radiology 42:224, 1944.

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## Mass Health Surveys in Industry

A statement prepared by the Council on Industrial Health of the American Medical Association and approved for publication, follows:

An important component of industrial health examinations is the discovery of nonoccupational disease, often in incipient and readily manageable stages. Early detection of illness and prompt adequate treatment are in the best interests of the worker, the employer, the community and the medical profession.

Increasingly in recent years official and voluntary health agencies have regarded industry as a convenient avenue for special case-finding campaigns—especially tuberculosis, syphilis and defective vision. All have important relations to the general public health or are designed to improve production and earning power or to reduce troublesome absenteeism and wastage.

The Council on Industrial Health believes that these case-finding campaigns conducted in industry by outside agencies merit support and coöperation from the medical profession provided certain general principles are observed:

1. The local medical profession, health authorities and other affected community health facilities should be fully advised well in advance about the purposes and scope of the survey.

2. The personnel undertaking the survey must be professionally competent and employ acceptable equipment and procedure. Results of examinations should be interpreted by physicians of experience and training in the methods employed.

3. Mass health surveys are essentially screening operations. Unless preliminary agreement suggests otherwise, the details of confirmatory diagnosis should be regarded as responsibilities of the established medical, clinic or laboratory facilities in the community.

4. Full consideration needs to be given to the disposition of individuals with clinically significant findings. They should be promptly referred to personal physicians or other authorized community agency for additional study and individualized treatment.

5. Means for isolation, hospitalization or other essential treatment need careful evaluation in advance of the survey.

6. Reporting and epidemiologic investigation of communicable disease should conform with the regulations of the health department having jurisdiction.

7. Surveys should be conducted only after the plant medical service has had an opportunity to study the proposed activity and given its approval. The details of case finding should conform to accepted industrial health procedure and be integrated with the regular activities of the plant medical department. The industrial physician should be consulted particularly (a) on discovery of coincidental disease or disability having suspected occupational etiology, (b) regarding plans for referral of patients and follow-up and (c) about the details of reemployment, especially placement in suitable occupations of individuals with residual impairment.

Most of our cases of active pulmonary tuberculosis in years to come will develop from the group of school children who are reactors to the tuberculin test today. It is important to stress that all such reactors should be carefully watched, x-rayed annually and, wherever possible, the source of infection traced to prevent further spread of the disease. When an individual reacts to tuberculin, two important facts are immediately established: (1) the individual is at least a potential case of clinical tuberculosis; and (2) there has been a source of infection which may be sought among contacts.—Lewis S. Jordan, M.D., *Journal-Lancet*, April, 1945.

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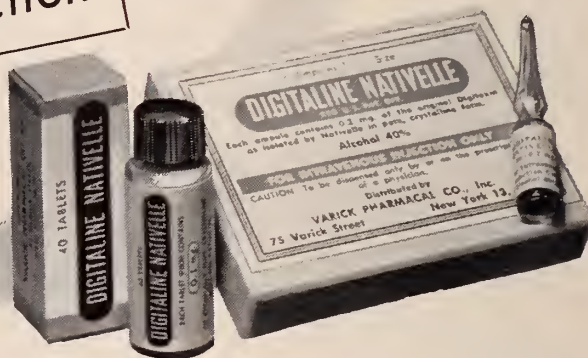
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<sup>1</sup> N.N.R., 1941, page 210.

<sup>2</sup> Gold, H.; Cartell, M.; Modele, W.; Kwit, N. T.; Kramer, M. L., and Zahm, W.: J. Pharmacol. & Exper. Therap. 82:187 (Oct.) 1944.

Digitaline Nativelle is available through all pharmacies in 0.1 mg. tablets (pink) and 0.2 mg. tablets (white), each in bottles of 40 tablets. Also in 0.4 mg. (2cc.) and 0.2 mg. (1cc.) ampuls, each in boxes of 6 ampuls, for intravenous use when the oral route cannot be employed.

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\* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154  
*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

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LITERATURE ON REQUEST


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### What Price Social Security?

What price social security?

In the first, bright heyday of social security legislation, it was considered rank heresy to ask that question—but a staff of experts finally has gone to work in Washington to dig up the answer!

Congress, showing signs of alarm at the juggernaut it has set in motion, is viewing the scores of blueprints for new social services now pending before it with mounting suspicion, and is demanding either definite price tags or carefully tabulated cost estimates.

The figures, when they are finally made public, may well startle the Nation, for surveys already completed by an independent agency, the Research Council for Economic Security, have revealed that the expanded social security system now contemplated in legislation before Congress would cost 20 billion dollars a year.

If assessed against a working force of 60 million men and women, that would mean a cost per wage-earner of \$333 a year—either in payroll deductions or other forms of direct and indirect taxation!

From the staff of experts set up by the House Ways and Means Committee to study costs of the various new social security proposals has come a preliminary estimate that just one of the measures now pending—the Wagner-Murray-Dingell bill—would require a payroll tax of at least 12 per cent and possibly 14 to 15 per cent to finance its elaborate framework of compulsory health insurance, disability and maternity allowances, hospitalization benefits, etc.

"That's too much," barked one of the members of the Ways and Means Committee, when the report was read. "The country won't stand for it!"

And Congress, for the first time since Uncle Sam

(Continued on Page 50)



# COMPLICATIONS FROM PENICILLIN

The use of purer penicillin has markedly reduced such complications as phlebitis, pain at the site of injection, pyrexia, vascular and sympathetic disturbances, as well as muscular cramps.\*



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\*Keys, J.E.L.: Penicillin in Ophthalmology, J.A.M.A. 126: 610 (Nov. 4) 1944.

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**F. E. YOUNG & CO., 432 E. 75th St., Chicago 19, Ill.**



### WHAT PRICE SOCIAL SECURITY?

(Continued from Page 48)

donned the habiliments of an all-year Santa Claus, is beginning to have serious doubts on two scores: First, do the people have any idea what an expanded social security system will cost them? Second, when they learn the cost, will they put up with it—or will they rebel and fire the congressmen who voted it?

California legislators, soon to meet in special session, must also try to answer the same questions, for the pressure from the CIO and other labor groups for extended social security benefits is almost as heavy in Sacramento as in Washington, with Governor Warren apparently inclined to go along with them in their demands.

That puts the problem right in the laps of the legislators—and the lawmakers, knowing the people back home already are grumbling about taxes and payroll deductions, are anything but happy at the prospect. The Legislature, too, can be expected to start digging into costs—before its members answer roll-call!—Clem Whitaker, in "California Feature Service."

### Surgeon General of Army Announces New Officer Release Policy

A revised point system program which will return 13,000 physicians, 25,000 nurses, 3,500 dentists and an un-

determined number of other Medical Department officers to civilian life by January 1, 1946, was announced September 14, 1945, by Major General Norman T. Kirk, the Surgeon General.

Under the plan those Medical and Dental Corps officers who have 80 points, are 48 years of age or have been in the Army since before Pearl Harbor will be released as surplus officers unless they are specialists in eye, ear, nose and throat work; plastic surgery, orthopedic surgery, neuropsychiatry or are laboratory technicians. These specialists will be released if they were called to active duty prior to January 1, 1941.

This is a drastic lowering of points below the previous plan which was based on an adjusted service score of 100 for non-scarce Medical Corps officers and 120 for those in scarce categories.

It is also anticipated that, on the basis of an army of 2,500,000 men, a total of 30,000 doctors, 40,000 nurses and 10,000 dentists will be released by July, 1946, and if the armies of occupation and troops in the United States are concentrated at large posts these figures will be exceeded. These figures represent approximately 70 per cent of the peak strengths at VE-Day of these corps.—From a Technical Information Division Bulletin, Office of Surgeon General, Washington, D. C., September 15, 1945.



**WHEN** *digestive symptoms and general malaise are accompanied by marked downward displacement of the viscera, they are often relieved by ANATOMICAL SUPPORT.*



*X-Ray of patient with visceroptosis. (Left) The lesser curvature of the stomach is below the crests of the ilia. (Right) X-Ray of same patient after application of Camp Support for visceroptosis indicating how the viscera is held in a more nearly normal position.*

## Visceroptosis Support – **CAMP**

The roentgenologist may or may not find disturbed conditions in the duodenum...the displaced viscera being the only finding.

For these patients, many physicians prescribe adequate rest, proper food at regular intervals, graduated exercises (especially for the patient with “visceroptotic habitus”), and a scientifically designed anatomical support. Numer-

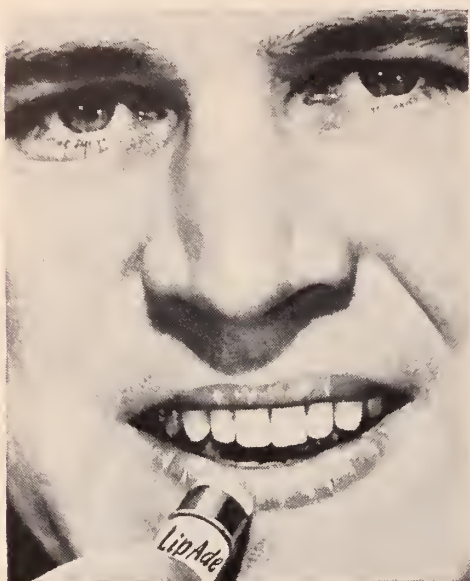
ous reports show that this treatment results in the gradual disappearance of the digestive symptoms with improvement in general health and weight gains for the thin patient. In time the support may be discarded.

Camp Supports are also of assistance for postural defects that so frequently accompany the visceroptotic condition.



*Camp supports for visceroptosis are fitted and adjusted with the patient in the partial Trendelenburg position. Pads are frequently used under the direction of the physician.*

S. H. CAMP & COMPANY • Jackson, Mich. • *World's Largest Manufacturers of Scientific Supports*  
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Mitigates discomfort of lips parched by fever or exposure. Contains intimate mixture of mineral oils and waxes — is non-irritating, protective, hypo-allergenic.

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## Restoration of Sight in Scarred Cornea Through Corneal Grafts

How sight can be restored to some blind persons through the corneal grafting operation is described by Dr. R. Townley Paton, New York ophthalmologist, in *Sight-Saving Review*, quarterly journal of the National Society for the Prevention of Blindness. Dr. Paton is a member of the Society's Board of Directors and vice-president of the Eye-Bank for Sight Restoration, Inc., c/o National Society for Prevention of Blindness, 1790 Broadway, New York City (19).

It is estimated that there are 250,000 blind people in the United States and that approximately 22,000 of them have corneal scars. At least 10,000 might avail themselves of the corneal graft operation. Some cases, however, are not suitable for the operation, due to advanced age, secondary glaucoma, retinal, uveal or optic nerve disease.

The technique of the present-day operation is so relatively new that few ophthalmologists have had an opportunity to acquire it. Although there are many eye surgeons capable of performing this operation, only a small number, ten or fifteen, have become experts in this special field of eye surgery. Few have done over 100 operations to date. Another reason the operation has not been more frequently performed is the unavailability and difficulty of obtaining fresh corneal tissue. These difficulties will be overcome, however, by the activities of the recently established Eye-Bank for Sight Restoration, Inc.

The corneal grafting operation, for an experienced eye surgeon, is a relatively simple procedure. The transplanting of suitable healthy tissue to the cornea of the patient's damaged eye may be done in twenty minutes. Though many of the early attempts at the operation were only partially successful, during the past ten years the results, so far as improvement of vision is concerned,

(Continued on Page 54)



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1 LEVEL TABLESPOON

2 OUNCES

2 FLUID OUNCES

40 CALORIES  
(APPROX.)

20 CALORIES  
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ACME BREWERIES • San Francisco, Los Angeles



### RESTORATION OF SIGHT IN SCARRED CORNEA THROUGH CORNEAL GRAFTS

(Continued on Page 62)

have become permanent in about 80 per cent of the cases. In a recent series of 100 carefully selected cases, only two complete failures were met with.

The care of these patients follows the routine of cataract patients. Both eyes are kept bandaged for three or four days, and the sutures are removed from the fifth to seventh day; the patient is allowed out of bed in a week, or sooner, with the average hospitalization being from ten days to two weeks. The complications resulting from this type of operation are fewer than those following cataract extraction. Follow-up care is confined to weekly visits to the physician or clinic for a period of about a month; at the end of this time the patient is discharged unless complications have developed.

At the present time, according to Dr. Paton, the corneal tissue taken from a living or dead person may be stored for only a few days before it is transplanted but "the time will come when corneal tissue may safely be preserved for several weeks; much research work on this subject still needs to be done."

The Eye-Bank for Sight Restoration is national in scope, has been incorporated under the laws of New York State, and 32 leading hospitals in New York City are now affiliated with it. The Eye-Bank collects and preserves healthy corneal tissue from human eyes for transplanting to blind persons who have lost their sight because of corneal defects.

In addition to handling the mechanics of supplying healthy corneal tissue, the Eye-Bank hopes to extend, through scholarships and fellowships, the knowledge and skill required to perform this delicate operation. Six thousand physicians are qualified to practice ophthalmol-

ogy in the United States, of which 4,000 also specialize in ear, nose and throat. Perhaps less than one per cent of these physicians would be willing to acquaint themselves with the technique of the operation and postoperative follow-up care of patients upon whom the operation has been performed.

Another objective is to discover improved methods for preservation of the corneal tissue over a long period of time than is now possible. At the present time, the corneal tissue taken from a living or dead person may be stored for only two to three days before it is transplanted. Corneas obtained from a dead person must be removed within a few hours after death. It is necessary to have the consent of the next of kin for a post-mortem removal of an eye, even though the deceased left written instructions for the use of his eyes in this way.

**On Drug Purchases.**—The interdependence of physician, pharmacist and manufacturers of packaged medicines is sharply pointed up by some recently compiled statistics:

Analyzing 5,000 prescriptions, Dr. Henry Burlage of the University of North Carolina found that some 60 per cent of them included proprietary drugs; that most of this 60 per cent called for only one proprietary and required no compounding. These and other results of the survey are published in the June issue of the *American Druggist*.

The Milbank Memorial Fund found that 56.7 per cent of the people buying medicine for ailments, buy without a doctor's prescription. The breakdown is as follows: 32.2 per cent of medicines are sold on the druggists' recommendation; 43.3 per cent on physicians' prescriptions; 11.7 per cent by "other methods" including recommendation (but not prescription) by physicians. Results appear in the *Louisiana Pharmacist* June issue.

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The greatest number of fatal injuries in home accidents, about one-fourth of the total, resulted from injuries suffered in the bedroom, and the proportion was the same for men as for women. Not unnaturally, a high proportion, namely one-half, of the deaths from injuries in the bedroom occurred from asphyxiation by gas or from conflagration, calamities which may overtake sleeping persons before they have a chance to save themselves

or even to become aware of the danger. Incidentally, the poisonous gases and the conflagrations in many of these cases originated in areas other than the bedroom in which the victim was actually injured. As to poisonous gases, in three-quarters of the cases among men, and in two-thirds of those among women, the source of the poisonous gas was in another part of the house, as, for instance, in the kitchen or in the cellar. Of the fatal injuries from conflagration sustained by men in the bedroom, two-fifths resulted from fires originating in other areas; among females the corresponding proportion was two-thirds. In many cases, the origin of the fire which had reached the bedroom was in the kitchen or living room.

Falling on the floor, or out of a window, or simply out of bed, caused a good number of the deaths charged to the bedroom. Among females, deaths thus caused were exceeded only by those due to conflagration. Burns other

(Continued from Page 52)



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## HAZARDOUS AREAS IN AND ABOUT THE HOME

(Continued from Page 58)

than from general conflagration, in a group of 729 deceased persons selected for the study here quoted from, caused the death of 13 men and 15 women, and more than half these fatalities in each case were caused by smoking in bed. An appreciable number of persons died as the result of taking an overdose of sleeping drugs.

The kitchen was the scene of the second largest num-

ber of fatal injuries to women; in fact, 20 per cent of fatal injuries to women in the home were suffered in this room. In view of the fact that a housewife spends a good part of her time around the stove, it is not surprising to find that fatal burns occurred in the kitchen more than in any other area. The number of deaths by falls among women was the same in the kitchen as in the bedroom. Men, too, had their share of fatal injuries in the kitchen, about 10 per cent of their total fatalities in the home. Gas poisoning was the leading cause in these cases.

From the nature of things, stairs and steps present a special risk of fatal falls. One-fifth of the deaths among men were referable to this cause, making stairs and steps the second ranking area as a home hazard for them. Among women, the number of fatal injuries received on stairs and steps was only slightly less than the number in the kitchen. The area around the house—the backyard, the garden, and the driveway—contributes materially to the annual toll from home accidents. In fact, among men in this urban insurance experience, a greater number of fatal accidents occurred in the outdoors around the house than in any room except the bedroom.

A relatively small proportion of the fatal injuries were suffered in the bathroom, 2 per cent among men and 4 per cent among women. Falls were the leading cause in these cases. Of six accidental drownings in and about the house, four took place in the bathroom. These may be said to represent rather exceptional situations; for example, in three cases the victim had an epileptic fit or fainted while standing in or near a filled bathtub.

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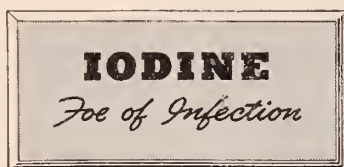
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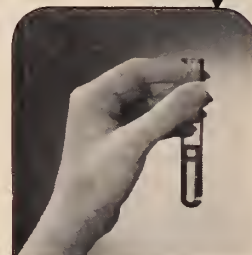
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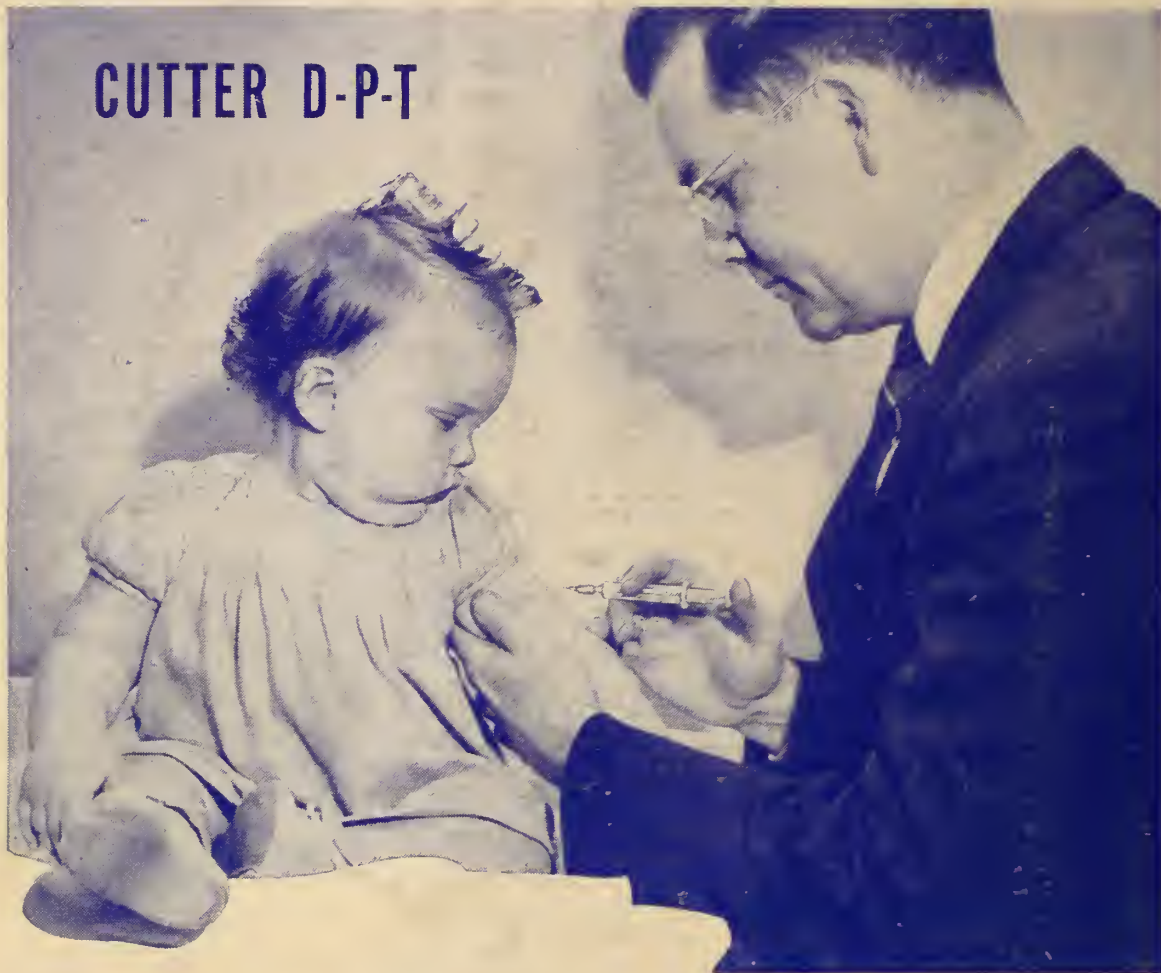
During the last twelve years, these products have been used in a great deal of clinical investigation of various aspects of nutrition, which have been reported in the scientific literature.

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Hamilton, P. M., and Knouf, E. G.; *J. of Ped.*, 25:238; Sept. 1944. \*\*Miller, J. J., and Saito, T. M.; *J. of Ped.*, 21:31-44; July, 1942.

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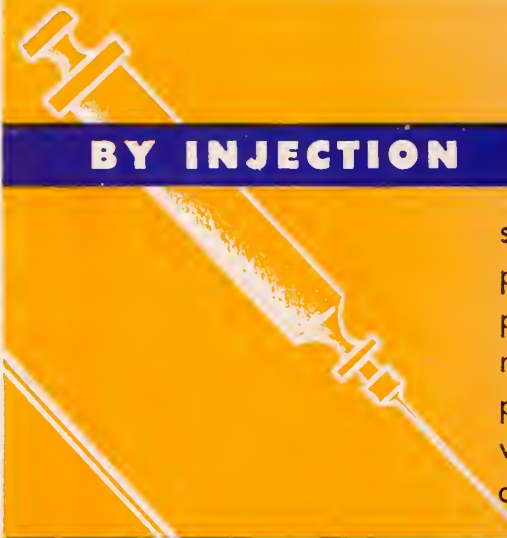
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Edwin L. Bruck.....San Francisco	1945		Dwight H. Murray (Chairman).....Napa	1947	
Lloyd E. Kindall.....Oakland	1945		Lloyd E. Kindall.....Oakland	1948	
Committee on Associated Societies and Technical Groups			Association President .....ex officio		
John V. Barrow (Chairman).....Los Angeles	1946		Association President-Elect .....ex officio		
Anthony B. Diepenbrock.....San Francisco	1947		Advisory Committee		
Edward F. Nippert .....Hollywood	1948		Junius B. Harris (Chairman).....Sacramento		
Committee on Health and Public Instruction			H. R. Madeley (Vice-Chairman).....Vallejo		
J. C. Geiger (Chairman).....San Francisco	1946		Wilson Stegeman .....Santa Rosa		
E. Earl Moody .....Los Angeles	1947		Committee on Scientific Work		
C. M. Burchfiel.....San Jose	1948		George H. Kress (Chairman).....ex officio		
Committee on History and Obituaries			Fletcher B. Taylor.....Oakland	1946	
Hyman Miller .....Los Angeles	1946		J. Homer Woolsey .....Woodland	1947	
Morton R. Gibbons, Sr. (Chairman).....San Francisco	1947		Howard F. West.....Los Angeles	1948	
Robert A. Peers.....Colfax	1948		Francis L. Chamberlain (ex officio, Secretary, Section on Medicine)		
George H. Kress.....ex officio			Eugene J. Joergenson..(ex officio, Secretary, Section on Surgery)		
Committee on Hospitals, Dispensaries and Clinics			Committee on Public Relations		
Benjamin W. Black.....Oakland	1946		The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio.		
Roy E. Thomas .....Los Angeles	1947		J. C. Geiger.....Chair, Com. on Health and Public Instruction		
Clarence E. Rees (Chairman).....San Diego	1948		Clarence E. Rees..Chair, Com. on Hospitals, Dispensaries, Clinics		
Committee on Industrial Practice			Donald Cass.....Chair, Com. on Industrial Practice		
Carl L. Hoag.....San Francisco	1946		Nelson J. Howard.....Chair, Com. on Medical Defense		
N. P. Dunne .....Oakland	1947		Carl L. Mulfinger..Chair, Com. on Membership and Organization		
Donald Cass (Chairman).....Los Angeles	1948		H. Gordon MacLean.....Chair, Com. on Medical Economics		
Committee on Medical Defense			Dwight H. Murray, Chair, Com. on Public Policy and Legislation		
Louis J. Regan.....Los Angeles	1946		F. E. Clough.....Chair, Com. on Postgraduate Activities		
Nelson J. Howard (Chairman) .....San Francisco	1947		Philip K. Gilman...President of California Medical Association		
William A. Key.....San Mateo	1948		Sam J. McClendon.....President-Elect		
Committee on Medical Economics			George H. Kress.....Secretary-Treasurer		
Howard W. Bosworth.....Los Angeles	1946		Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2004, 450 Sutter Street, San Francisco.		
Wayne J. Pollock.....Sacramento	1947		Cancer Commission		
H. Gordon MacLean (Chairman).....Oakland	1948		Lyell C. Kinney (Chairman).....San Diego	1946	
Committee on Medical Education and Medical Institutions			Harold Brunn .....San Francisco	1946	
William J. Kerr.....San Francisco	1946		Orville N. Meland (Sec'y, Southern Calif.)..Los Angeles	1946	
B. O. Raulston (Chairman).....Los Angeles	1947		George Sharp .....Pasadena	1947	
L. R. Chandler.....San Francisco	1948		Whitfield Crane (Vice-Chairman).....Oakland	1947	
Committee on Organization and Membership			Gertrude Moore .....Oakland	1947	
L. H. Redelings.....San Diego	1946		Henry J. Ullmann.....Santa Barbara	1948	
Carl L. Mulfinger (Chairman) .....Los Angeles	1947		David A. Wood (Sec'y, No. California)....San Francisco	1948	
Harold G. Trimble .....Oakland	1948		James F. Rinehart.....San Francisco	1948	
Committee on Postgraduate Activities			Physicians' Benevolence Committee		
F. E. Clough (Chairman).....San Bernardino	1946		Axel E. Anderson, Chairman.....Fresno		
H. F. Freidell.....Santa Barbara	1947		Elizabeth M. Hohl.....Los Angeles		
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## Miscellaneous California Medical Organizations

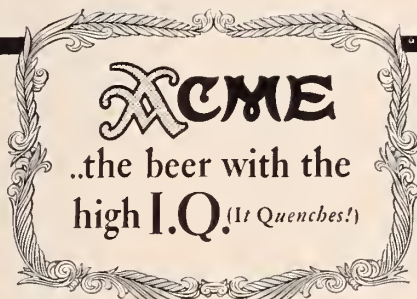
<b>Board of Medical Examiners of the State of California</b> San Francisco, 2—Room 214, 515 Van Ness. Los Angeles—906 State Building. Sacramento—Business and Professional Building, 1020 N Street, Room 536. Secretary, Frederick N. Scatena, M. D., 1020 N Street, Room 536, Sacramento, 14.	<b>Department of Public Health of the State of California</b> San Francisco—1122 Phelan Building, 760 Market Street, San Francisco, 2; Underhill 8700. Sacramento—631 J Street. Los Angeles—State Office Building, 217 West First Street, Madison 1281. Director, Wilton L. Halverson, 603 Phelan Building, 760 Market Street, San Francisco, 2.	<b>Southern California Medical Association</b> President, Reginald H. Smart, 1136 West Sixth Street, Los Angeles. Secretary, Nelsop P. Anderson, 2007 Wilshire Boulevard, Los Angeles.
<b>Medical Society of State of California</b> Optional Medical Defense—C. M. A. Members. Room 2008, Four Fifty Sutter, San Francisco, 8.	<b>The Public Health League of California</b> Executive Secretary, Ben H. Read, San Francisco (8) office, 251 Kearny Street, phone SUTTER 8470. Los Angeles office, Room 353, 1151 So. Broadway 15, phone PROspect 5711.	<b>Medical Schools in California</b> University of California Medical School, Medical Center, San Francisco, 22. Stanford University School of Medicine, 2398 Sacramento St., San Francisco, 15. School of Medicine, University of Southern California, 3551 University Ave., Los Angeles, 7. School of Medicine, College Evangelists, 312 N. Boyle Ave., Los Angeles, 33.

(For roster of County Society officers, see last month's issue.)



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(Continued from Page 3)

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Hospital Service of Southern California, 743 South Grand View Street, Los Angeles. (Phone DRExel 5261.)

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento. (Main 2548.)

## California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MONTrose 3600.

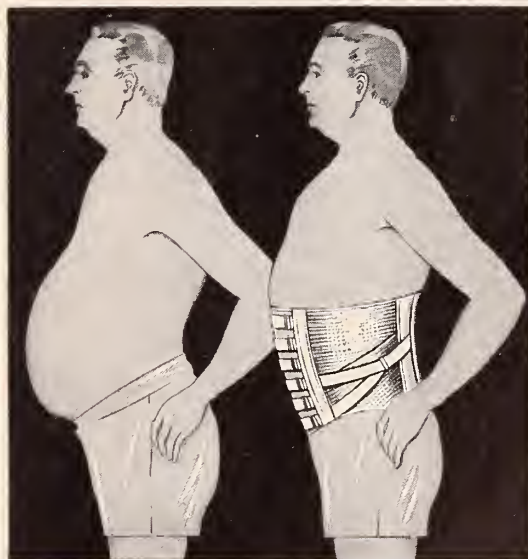
Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WESt 8000, Extension 75.

Barlow Medical Library (Los Angeles County Medical Association), 634 So. Westlake, Los Angeles 5. Phone FItzroy 7694.

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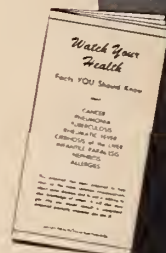
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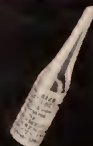
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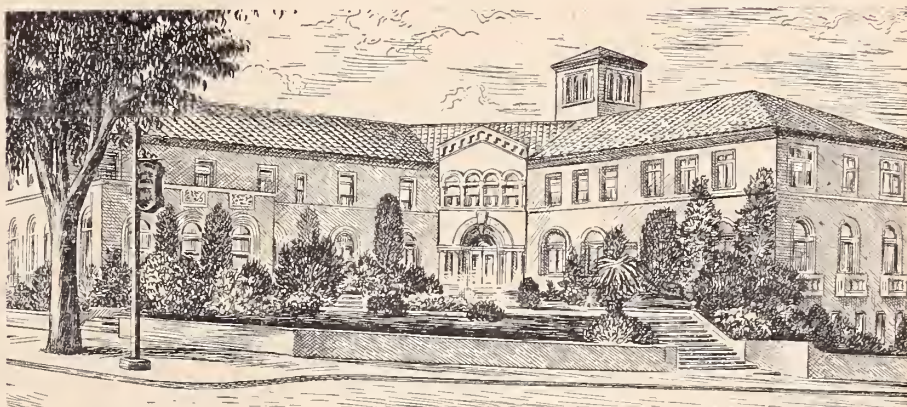
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## BOOK REVIEWS

### BOOKS RECEIVED

**Essentials of General and Scientific Latin.** By George W. Currie, Ph.D., formerly Professor of Latin and Greek in Birmingham-Southern College; now at Millsaps College. Cloth. Price, \$1.25. Pp. 118. Boston: Chapman & Grimes, Inc., 1945.

**Physical Chemistry of Cells and Tissues.** By Rudolf Höber, University of Pennsylvania School of Medicine, Philadelphia, Pa.; with the collaboration of David I. Hitchcock, Yale University School of Medicine, Laboratory of Physiology, New Haven, Conn.; J. B. Bateman, Mayo Clinic, Rochester, Minn.; David R. Goddard, University of Rochester, Biological Laboratories, Rochester, N. Y., and Wallace O. Fenn, University of Rochester, School of Medicine and Dentistry, Rochester, N. Y. Cloth. Price, \$9.00. Pp. 676, illustrated. Philadelphia: The Blakiston Company, 1945.

**Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association.** For 1944, with the comments that have appeared in *The Journal*. Cloth. Pp. 238. Chicago: American Medical Association, 1945.

**New and Nonofficial Remedies, 1945.** Containing Descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1945. Issued under the direction and supervision of the Council on Pharmacy and

(Continued on Page 14)

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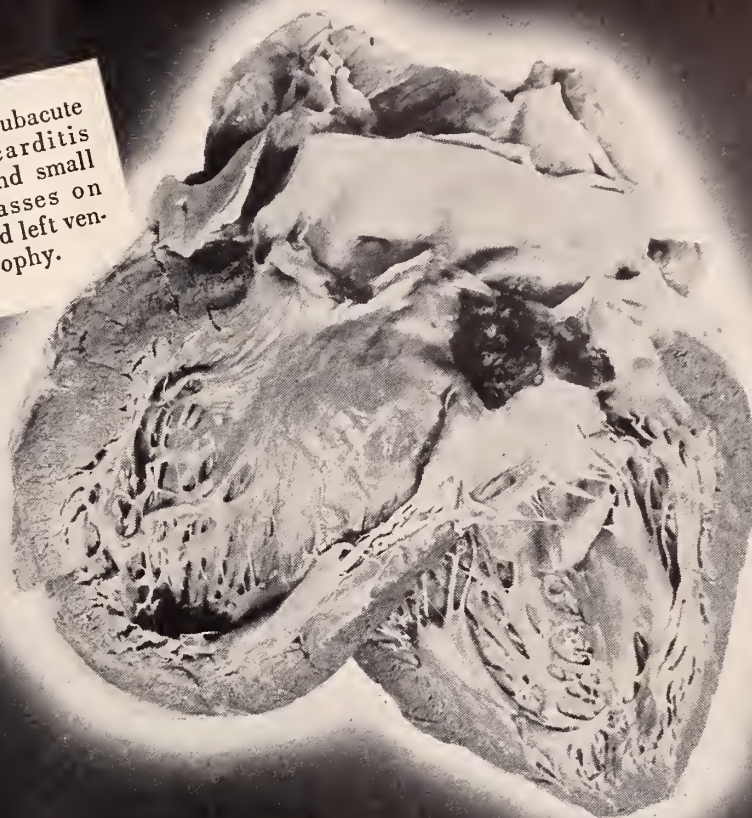
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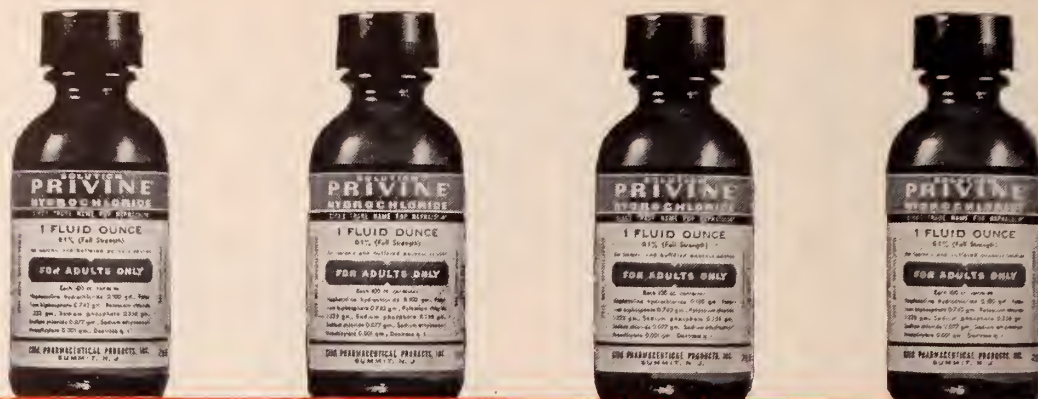
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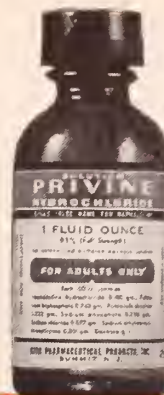
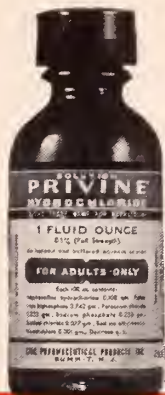
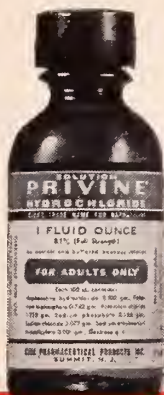
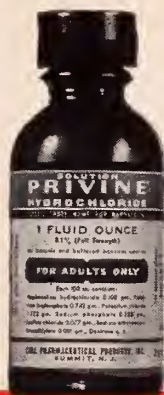
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## BOOKS RECEIVED

(Continued from Page 7)

Chemistry of the American Medical Association. Cloth. Pp. 760. Chicago: American Medical Association, 1945.

**American Red Cross First Aid Textbook.** Prepared by the American Red Cross for the Instruction of First Aid Classes. Paper. Pp. 254, revised with 264 illustrations. Philadelphia: The Blakiston Company, 1945.

### Rôle of Education in Control of Cancer

*Public to Be Enlisted to Aid Battle Against Disease*

Newspapermen the world over agree that the announcement of a cure of cancer, when it comes, will be one of the greatest news stories of all times. That day hasn't arrived yet. . . .

Time was, according to Mrs. Harold Bogert, western director of the American Cancer Society, who was re-

cently in San Francisco, that public fear of tuberculosis and venereal disease was as great as is the fear of cancer today. Through knowledge and education, that fear has been in great measure changed to hope. She and other men and women of the Society believe that through education and knowledge, if spread widely enough, the same change can be brought about in public reaction to the control of cancer.

In conferences with Mrs. Ryer Nixon, California State President of the American Cancer Society, Mrs. Bogert stated she has been outlining organization plans in co-operation with the California Medical Society and public health officials.

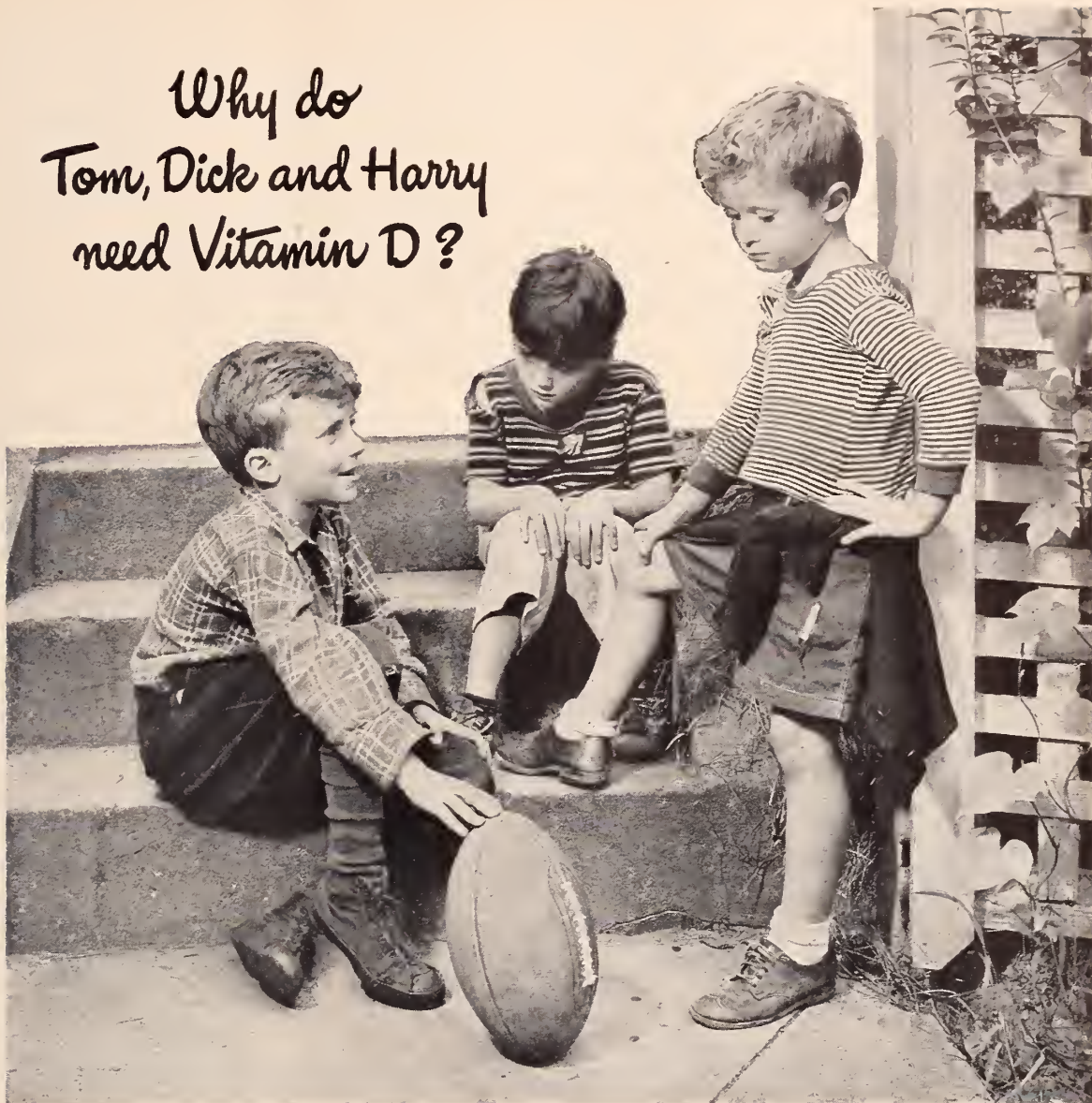
Specifically, Mrs. Nixon announced, "we hope to have cancer education included in the high school curriculum, and we are conferring with local and State educators this week. . . .

"California has less legislation to provide for needy

(Continued on Page 16)



# Why do Tom, Dick and Harry need Vitamin D?



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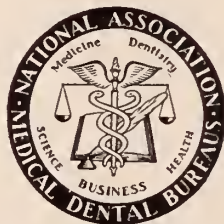
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### ROLE OF EDUCATION IN CANCER

(Continued from Page 14)

cancer patients that any other State in the Nation, with the exception of Tennessee," Mrs. Nixon commented. "There is need for transportation of patients to clinics, for many counties have no diagnostic clinics, and none which can give treatment. There is need for more hospital beds for those who must have lengthy care, and cannot pay regular hospital rates. More clinics are needed.

"The problem is a large one, but we are going to work on it now that the war is over. When the public realizes how backward California is in relation to cancer control and treatment, the public will demand changes. We hope to bring about that realization."—San Francisco *Examiner*, October 4.

### TWENTY-FIVE YEARS AGO

(Continued from Text Page 316)

profession. . . . The essentials are few but important. We have got together on these essentials in the "League for the Conservation of Public Health." When we are agreed, when we are unanimous, when we unite on the great essentials, the campaign just closed shows what will result. Therefore the key to the future is again, organization, organization, a League for the Conservation of Public Health which represents the essential unity of the medical profession and which by efficient, skilfully directed organization does the work in a big way which all of us together as individuals could not even touch. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

*From an Article on "The Education and Training of*

*(Continued on Page 17)*





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### TWENTY-FIVE YEARS AGO

(Continued from Page 16)

the Modern Surgeon," by Andrew Stewart Lobingier, A.B., M.D., F.A.C.S., Los Angeles.—The modern student of medicine still suffers from the lack of balance and perspective in the curriculum offered for his training. One wonders if we shall ever get away from time-worn and obsolete methods; if we shall ever realize the years required to mature the scientific student in the manner and the method of acquiring knowledge. . . .

From an Article on "Magnet Extraction of Foreign Bodies with Particular Reference to the Importance of Accurate Localization," by Hans Barkan, M.D., San Francisco.—The removal of foreign bodies from the eye by some magnetic implement is not a modern maneuver,

but was practiced in isolated cases and in very rough form in the middle ages. The accurate methods of removal and localization are, however, of fairly recent origin. Dixon of London in 1859, is first on record as having drawn from the posterior chamber through a scleral incision a part of a blade of scissors. In 1874 McKeown of Belfast, also through a scleral incision, removed a foreign body with a specially constructed magnet.

The names of Snell, Sulzer, Schlosser, Hirschberg and Haab follow each other in rapid succession, each improving on some form of magnet until 1892 when the last named constructed his famous giant magnet which, with slight modifications, is still the most powerful magnet of them all. . . .

From an Article on "Retroversions of the Uterus," by Frank W. Lynch, M.D., San Francisco.—The older teach-

(Continued on Page 20)

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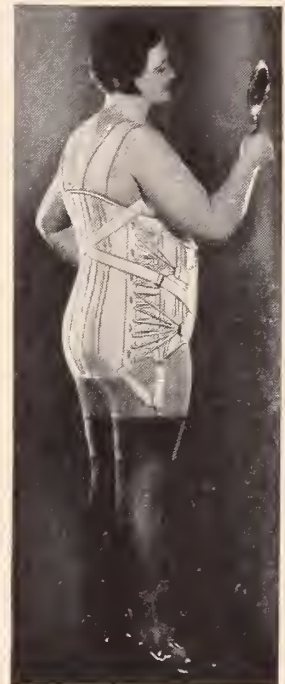
2 They may be reinforced with pliable steels or the Camp spinal brace as desired by the Orthopedic Surgeon or Physician . . .

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### TWENTY-FIVE YEARS AGO

(Continued from Page 17)

ing of Schultze that retroversions and retroflexions of the uterus were abnormal positions that invariably caused symptoms has been succeeded by the opposing view of Theilhaber. Nearly all agree at present that a uterus may be in any position, provided that it is movable, and that symptoms will not occur unless the organ is diseased or is associated with tubal or ovarian pathology. . . .

From an Article on "Reconstructive Surgery of the Shoulder," by John C. Wilson, M.D., Los Angeles.—The greatest values of military surgery are their practical applications to civil life. Whereas the average man will see many cases of a certain type during his lifetime, the opportunities for observation are increased many fold by such an international holocaust as the one we have just

passed through. Functional reconstruction of the shoulder has been much discussed. Arthroplasty has had its exponents, shoulder joint resection has had its merits extolled and arthrodesis has been commended, but no definite unification of opinion has followed concerning them until the tremendous number of cases in which the shoulder joint had been damaged were available for study during this war. . . .

*Excerpt from Correspondence: Methodists for Scientific Animal Experimentation:*

To the Editor: I am enclosing herewith a copy of a resolution passed at the recent session of the California Conference of the Methodist Episcopal Church, held in Oakland. It will go far, I believe, to show that at heart the Church is sound in its bearing toward scientific medicine and that the chiropractic propaganda alleged to have

(Continued on Page 22)





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## TWENTY-FIVE YEARS AGO

(Continued from Page 20)

been issued from the Book Concern Building cannot represent the mind of the Church in general, but is of local and limited origin, and from the stigma of which the Church could clear itself. Very truly yours,

R. T. STRATTON.

The following resolution was adopted by the California Annual Conference of the Methodist Episcopal Church at its late session in Oakland:

"The practice of medicine is not an exact science, and from the nature of the case cannot be. Yet the progress made in this profession is among the most wonderful in the achievements of mankind. In the relief brought to human suffering and the practical mastery of the great scourges of age-long diseases the medical profession has won for itself the high appreciation of man. The knowledge and practice by which they have so signally succeeded have come to them in a considerable degree by

vivisection, a practice that produces some pain, but by which man is relieved from many-fold degrees of suffering. By their investigations and earnest service they will doubtless make greater advancement in that knowledge which will bless the world. We wish to record here our high appreciation of their services and to declare our purpose to take a reasonable interest in their work and the protection of their privileges."

### Closed Shop Medical Practice

There has been no formula devised by which human ills can be brought under the wage and hour laws; sickness will probably never be put on a 40-hour weekly basis with time and a half for overtime. That being true, it seems odd that the proposed Wagner-Murray-Dingell bill would virtually create a closed shop of doctors; only those participating in the scheme would be available to a patient, except at his own expense.

(Continued on Page 26)

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\*N. Y. State Journ. Med. 35 No. 11,590 \*\*Laryngoscope 1935, XLV, No. 2, 149-154

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### CLOSED SHOP MEDICAL PRACTICE

(Continued from Page 26)

The proponents of the Wagner-Murray-Dingell bill insist that it will provide adequate medical care for the masses at cut-rate prices, yet the chances are that many competent and successful medical practitioners will not subscribe to the socialization scheme unless forced to do so. . . .

Under the impact of sickness, the first thought is for the best talent. The health and well-being of a loved one is not something one buys at a bargain counter.

The sincerity and idealism of those writing the bill is not in the least questioned; the widespread benefits to be gained by many from some sort of health insurance formula are likewise beyond question. But the application of the closed shop philosophy; however unintentional, to the medical profession, and the reducing of medical care to the bargain counter status, will not be productive of the desired ends.—San Francisco *Life*, September.

### BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 316)

"New evidence in the alleged abortion mill of Mrs. Inez Burns at 325-7 Fillmore Street yesterday, brought another arrest in the case, the possibility of still others and re-arrest on more serious charges against two of the accused. Mrs. Mabel Spaulding, 56, of 3834 Fulton Street, said to be a secretary-bookkeeper-receptionist at Mrs. Burns' elaborate clinic, was arrested and charged with conspiracy to commit abortions. At the same time the charge against Mrs. Burns, 57, was changed from 'suspicion of conspiracy to commit an abortion' to 'conspiracy to commit abortions.' Her alleged accomplice, Joe Hoff, 54, of 3481 Pierce Street, recently released by police, was re-arrested on the new charge. . . . Mrs. Burns, also known as Inez L. Brown, was arrested September 26

(Continued in Back Advertising Section, Page 30)



# the obligations of victory

Victory, too, imposes obligations. The fruits of our efforts and the sacrifices of the past four years will be determined by our actions today.

There is much to be done if we are in some small measure to repay those who fought for us.

For those who died there are families to care for; those who were hurt must be brought back to health; and even those who returned without physical injury need to be helped back to a normal peacetime existence.

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# CALIFORNIA AND WESTERN MEDICINE

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EDITOR . . . . . GEORGE H. KRESS, M.D.

### Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

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F. Burton Jones.....	Vallejo	1947
R. H. Sundberg.....	San Diego	1948
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**Contributions—Length of Articles; Extra Costs.**—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

**Leaflet Regarding Rules of Publication.**—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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## EDITORIALS

### ON MOTIVATING INFLUENCES AND PERSONALITIES IN BACK OF PRESIDENT TRUMAN'S HEALTH (SICKNESS) INSURANCE MESSAGE, AND ITS IMMEDIATE LEGISLATIVE EXPRESSION, SENATOR WAGNER'S NEW BILL—S. 1606

**President Truman's Message.**—On Monday, November 19th the public press carried the story of the "Message from the President of the United States, transmitting his request for legislation for adoption of a National Health Program," sent by President Truman to the 79th Congress.

On the very same day, press announcements also stated Senators Robert F. Wagner of New York and James E. Murray of Montana had introduced Senate Bill S. 1606, in which most of the recommendations contained in President Truman's message had been incorporated.

The Wagner law now proposed—S. 1606—differs in some important parts from the prior Wagner-Murray bill, S. 1050, submitted by Senators Wagner and Murray on May 24, 1945 (for reference to latter, see CALIFORNIA AND WESTERN MEDICINE, June, 1945, p. 307). Concerning such differences, more later.

However, former S. 1050 and present S. 1606 do contain many procedures much alike, not only one to the other, but also regarding provisions indicated in President Truman's message. Therefore, it would be fair to assume the Senators (or their sponsors, representatives, co-workers or assistants), must have had an audience with the President of the United States or his assistants, concerning the drafting of the message Mr. Truman deemed proper to send to Congress on November 19, 1945.

In making these and other comments that follow there is no desire on the part of CALIFORNIA AND WESTERN MEDICINE to give the impression that this journal would quarrel with the President of the Nation concerning some of the desirable objectives in his message, with which the medical profession has long been in accord. What critical comment is here expressed, is presented only because the future health needs of the people of the United States are the major issues under discussion,—vitaly important subjects on which many physicians have a much more intimate knowledge, than is possessed by the lay Senators and others allied with them, who are the sponsors of legislation such as is proposed in S. 1606.

### How Much Work Can Any One Man Do?—

When, in contemplation, one considers the multitude of duties devolving upon the President of the United States, the hours given to commitments for diplomatic, political and other conferences, and that in the 24 hours of each day, some time must be taken by him for sleep and personal living, one may conclude (since the National Health Program is only one of other legislative measures of national and other importance now pending on his desk, such as housing and industrial reconversion, return of military personnel to our own shores), it was necessary for the President to rely in large part upon others in his entourage, to aid him in drafting the "National Health Program" as outlined in the message sent by him to Congress on November 19.

Since Senators Wagner and Murray are members of the President's own political party and have been the sponsors of previous Social Security legislation, it would not be unjust to assume that they have been included among the President's advisers. But, in Senators Wagner and Murray, again we deal with two lay legislators, likewise burdened with a multitude of political and other responsibilities. Moreover, their past support of proposed laws of the Wagner-Murray-Dingell type does not make them experts on best ways and means of maintaining a high quality of service in medical care, something far different from activities in their past professional and other careers. However, for argument's sake, it is agreed that the two Senators have read much on the subject of medical care. Also has been noted their willingness to accept many statements, both sound and unsound, used by them in support of some of their biased contentions.

\* \* \*

### Who Are the Background Agents or Agencies Sponsoring the Wagner and Similar Bills?

—Since Senators Wagner and Murray have become such prominent protagonists of their theories—(a polite term for some of their promulgations)—it should be evident that they must have had behind them or have been associated with advisers, understudies or assistants who gave them the material they have seen proper to incorporate in drafts of legislation espoused by them.

If so, in turn, the query may be put: Who are some of the persons, groups or organizations that have given or suggested to Senator Wagner of New York, Senator Murray of Montana, and Congressman Dingell of Detroit, the information and material contained in the drafts of their respective bills?

On this point, the *Journal of the American Medical Association*, (J.A.M.A., Dec. 1, 1945, p. 951) states:

"According to Arthur Sears Henning, 'the compulsory health insurance plan is chiefly the brainchild of Isidore S. Falk, research director of the Social Security Board, and Michael M. Davis, a member of the C.I.O. Political Action Committee.'"

An interesting article in *Medical Economics* (November, 1945, p. 36) refers to:

"a 'master plan' of the International Labour Organisation for socializing medicine in all countries of the world. No pipe-dream, this plan is already responsible for the establishment of state medicine in Chile and in New Zealand! Still more significant—though not generally known—is the fact that the Wagner-Murray-Dingell bill in this country was written largely by ILO (International Labor Organization) leaders and that those same leaders are a powerful element in the current campaign for its passage."

From the same article:

"What Americans serve among these experts? For medical planning, there are at least three (none of them physicians): Arthur J. Altmeyer, chairman of the United States Social Security Board; Isidore S. Falk, director of the SSB's Bureau of Research and Statistics; and Wilbur Cohen, its assistant director."

Also, from the article another paragraph, with an illuminating footnote:

"Of particular significance to the medical and allied professions is the International Labour Conference held in Philadelphia in 1944. At that session delegates\* adopted a medical care recommendation embracing 114 detailed proposals to guide the member states in developing their health services. A majority of the 114 proposals are embodied directly or by implication in the Wagner-Murray-Dingell bill of 1945 (S. 1050)."

\* \* \*

**Physicians should give the President's Message and S. 1606 Careful Thought.**—It is important that physicians keep in mind the background activities above referred to, since, if as stated, outside lay forces are the insidious or other promoters of the persistent propagandist campaigns on the desirability of having the United States legally adopt "Compulsory Health Insurance" (Compulsory Sickness Insurance) it follows that Doctors of Medicine practicing in the United States should immediately and collectively become aware of that important fact!

Otherwise, as in recent years, hundreds of thousands of Americans will continue to be misled through the unsound philosophies and misinformation so insistently put forward by the proponents of a regimented, compulsory system of medical care.

If legislation such as has been proposed by Senators Wagner and Murray is enacted into law, the physical and other welfare of present and future generations of Americans will be greatly imperiled! Physicians cannot evade their responsibility to aid in preventing such a calamity. Something more than "alertness against sabotage" is indicated.

It behooves physicians, everywhere, to study

\* The U. S. delegation was composed of the following persons (none of them physicians) representing the groups specified:

**Government**—Senator Elbert D. Thomas (D., Utah), delegate; Assistant Secretary of State Adolphe A. Berle, Jr., substitute delegate for Miss Frances Perkins, the official delegate; Frieda S. Miller, Otis E. Mulliken, Charles W. Taussig, A. Ford Hinrichs, and Isador Lubin, advisers.

**Management**—Henry I. Harriman, former president, U. S. Chamber of Commerce, delegate; Henry S. Dennison, Charles Redding, and Clarence G. McDavitt, advisers.

**Labor**—Robert J. Watt, American Federation of Labor, delegate; William Green, president, American Federation of Labor, adviser; George Meany, adviser.



the implications contained in President Truman's message\*, and equally important, its legislative symbol, as expressed in the Wagner-Murray bill, S. 1606, which by indirection, now has the sanction of the Chief Executive of the United States.

To recapitulate:

(1) What kind of a medical profession would S. 1606 produce in the days to come?

(2) What kind of medical care would future generations of Americans receive under the proposed laws?

These are questions worthy of serious thought by all Americans.

**ON SELECTIVE SERVICE STATISTICS—TWO  
INTERPRETATION METHODS: ONE BY  
THE PRESIDENT OF THE UNITED  
STATES, THE OTHER BY AN EX-  
PRESIDENT OF THE CALIFOR-  
NIA MEDICAL ASSOCIATION**

**Selective Service Statistics in President Truman's Message as a Basis for Later Recommendations.**—Document 380 of the 1st Session of the 79th Congress is signed by Harry S. Truman, The White House, November 19, 1945. This document is President Truman's message on a "National Health Program" and was referred in the House of Representatives "To the Committee of the Whole House on the State of the Union and ordered to be printed".

Commencing at the bottom of the first page, President Truman started his statement concerning rejection statistics publicized by the U. S. Selective Service System. The figures presented were evidently intended to lay the foundation for subsequent comment, and to indicate changes that should be made in the existing system of medical care.

In other words, the Selective Service statistics were presumably used to furnish premises to conclusions applied and incorporated on the same day in Wagner-Murray bill, S. 1606.

The ease with which the Selective Service figures may be misinterpreted has been outlined in recent issues of *J.A.M.A.* and other publications.

Below appear excerpts from President Truman's message of November 19, after which are given quotations from the address of Dr. Lowell S. Goin, retiring president of the California Medical Association presented by him this year in Los Angeles, and printed in *CALIFORNIA AND WESTERN MEDICINE* for May, 1945.

Readers of *CALIFORNIA AND WESTERN MEDICINE* should peruse what President Truman had to say concerning Selective Service figures, and then scan Dr. Goin's analysis and breakdown of practically the same statistics, given some six months before President Truman sent his "National Health Program" to Congress.

\* \* \*

**How President Truman used Selective Service Statistics.**—Herewith, excerpts from President Truman's message:

\* In this issue President Truman's Message appears on page 270. Press comments on pages 298-304.

"The people of the United States received a shock when the medical examinations conducted by the Selective Service System revealed the widespread physical and mental incapacity among the young people of our Nation. We had had prior warnings from eminent medical authorities and from investigating committees. The statistics of the last war had shown the same condition. But the Selective Service System has brought it forcibly to our attention recently in terms which all of us can understand.

"As of April 1, 1945, nearly 5,000,000 male registrants between the ages of 18 and 37 had been examined and classified as unfit for military service. The number of those rejected for military service was about 30 per cent of all those examined. The percentage of rejection was lower in the younger age groups and higher in the higher age groups, reaching as high as 49 per cent for registrants between the ages of 34 and 37.

"In addition, after actual induction, about a million and a half men had to be discharged from the Army and Navy for physical or mental disability, exclusive of wounds; and an equal number had to be treated in the armed forces for diseases or defects which existed before induction.

"Among the young women who applied for admission to the Women's Army Corps there was similar disability. Over one-third of those examined were rejected for physical or mental reasons.

"These men and women who were rejected for military service are not necessarily incapable of civilian work. It is plain, however, that they have illnesses and defects that handicap them, reduce their working capacity, or shorten their lives."

\* \* \*

**Selective Service Statistics as Broken Down by Ex-C.M.A. President Goin.**—Having read the above, check may now be made with Dr. Goin's analysis:

**"SELECTIVE SERVICE STATISTICS**

"Since the five million 4F's are so frequently invoked, and since it is at first glance so shocking a figure, let us examine it in some detail. One difficulty with the argument is that intellectually it is not very honest. In Senator Pepper's interim report the figure is announced on page one not as five million, but as four-and-one-half million but on page three of the same report the graph discloses the true figure to be 4,217,000. An error of 13½ per cent can scarcely be considered insignificant.

"Of the total number rejected 444,800 were rejected as manifestly disqualified, that is to say the totally blind, the totally deaf, the deaf-mutes, the legless, the armless and so forth. It seems perfectly obvious that no program of medical care could have influenced this figure.

"701,700 were rejected for mental disease. Again I don't know of a program of medical care which would have prevented mental disease in these unfortunate people.

"582,100 were rejected for mental deficiency, that is to say that they were the imbeciles, the idiots and the morons. The most casual knowledge of eugenics would persuade anyone that this group does not constitute a medical problem, and these three groups together reach the large total of 1,727,600.

"When these have been excluded there remain 2,426,500 or somewhat less than half of the originally claimed five-million.

"Of this group 320,000 were rejected for muscular-skeletal defects, that is to say the clubfoot, the paralytic, the withered arm, the congenitally dislocated hip and so forth. Again I wonder what program of medical care might have made this group fit for military service.

"280,000 were rejected for syphilis. The statute books are already loaded with laws regarding syphilis. There

is probably not a community in the United States in which a person afflicted with this disease cannot secure treatment from the Department of Public Health. How, then, would compulsory health insurance have eliminated this group?

"220,000 were rejected for hernia. Hernia is a congenital defect and if a person is born with a defective inguinal or femoral canal he is likely to have a hernia and medical care has nothing whatever to do with the occurrence of hernia.

"160,000 were rejected for 'eyes.' Since eyes would seem to be useful adjuncts to men who were to be soldiers or sailors I presume that this means defective vision. If one is born with an eyeball too long or too short or one which is not a globe one will either wear glasses or not see very well and medical care has nothing whatever to do with it.

"Thus about one million more have been eliminated and the number of rejections on a basis of lack of medical care is about 1,500,000. Whether any program of medical care would have materially reduced this number is problematical.

"If the proponents wish to rest their case upon the need shown here (and they have made a great deal of it), I am content."

\* \* \*

Is it now in order to ask of CALIFORNIA AND WESTERN MEDICINE readers, this question:—

Having read both statements, what are your own conclusions?

#### ON "MEDICAL CARE INADEQUACIES"— WHERE AND WHY: IN RELATION TO RURAL AND URBAN PRACTICE, AND HOSPITALS AND PHYSICIANS

**"Medical Care Inadequacies"—A Much Abused Term.**—The term, "Inadequacies in Medical Care," has been subjected to so much misuse that whatever meaning it may still possess, depends in good part on the person who uses it.

That some individuals do not receive indicated medical care is not denied, and physicians have called attention thereto over many years. However, even though the inadequacies are related to disease and injury, to then place the blame for such upon the medical profession, is an evidence of lack of knowledge of actual facts, confused thinking and erroneous reasoning.

Proponents of "compulsory health insurance" are particularly prone to commit this offense. For, once having stated one imaginative premise (inadequacies of medical care), and their own opinion of the cause (the medical profession), they then use the term and the cause they have put forth, as premises from which to draw the conclusion that medical practice must be radically changed! (Inferentially, also that they, the reformers, are the proper persons to do this!)

The particular change they envision concerning medical practice may be summed up as "socialized medicine" (state medicine—political medicine), to be put into operation through a federal compulsory health (sickness) insurance law.

As stated above, the medical profession has long recognized that under certain conditions and in some places in the United States, inadequacies of medical care, may and at times, do exist. For discussion purposes, it may be worth while to call

brief attention to some of the reasons why inadequacies are present in rural and urban areas, and the ways in which hospitals and physicians may be concerned therewith.

\* \* \*

**(1) Inadequacies in Rural or Sparsely Settled Areas.**—California contains many sparsely settled areas in its expansive geographical domain. By the State's constitution, a county in California may erect and maintain a county hospital. Let us cite, as an instance, Alpine County, a Mother-Lode, Forty-Niner county,—credited in the 1940 census with a total population of 323 persons. How could that county erect and maintain a county hospital?

Other California county examples are Mono with 2,299, Sierra with 3,025, Trinity with 3,970 residents. California itself covers an area of 158,693 square miles. By contrast, Rhode Island has only 1,214 square miles, and Massachusetts, 8,257 square miles. Mono County with its population of 2,299 has one lone physician, and covers 3,030 square miles, an area almost half the size of Massachusetts!

In the wide open spaces of the Great West, portions of woodlands in the northern states, and the marshy and other sparsely settled regions of southern commonwealths, similar population figures may be found.

Yet, the proponents of compulsory socialized medicine plans not infrequently refer to the number of counties in the United States that do not have the advantages of up-to-date hospitals, health centers and other modern-day medical equipment, as if this deficiency in "number of counties" was a terrific arraignment!

The fallacy of such misleading information or reasoning, especially when used as texts or pleas to emphasize inadequacies in medical care that may exist in the United States, becomes evident when figures such as those above given for some of California's counties are taken into consideration.

It would be well if the Do-Gooder (often salaried) proponents who presumably have dedicated themselves to the campaign for elimination of medical care inadequacies, would first consider what are practicable and available ways and means to bring medical practice as it is carried on in metropolitan areas, to these less fortunately situated regions of our land.

It should be self-understandable that small county units often do not possess the taxation resources that would permit them to build (and even more difficult, maintain from year to year) the hospitals, health centers, laboratories, etc., etc., concerning which the reformers often prate at great length, and which, some of them seem to think, every citizen in the Union should supposedly have at his immediate beck and call.

Fortunately, at least in California, the public highways are so numerous and of such excellent construction that for patients suffering from serious illnesses or injuries, it is possible for the local physician to arrange for transportation to



a not too-far-distant consultant and hospital, so that human life is rarely menaced in these small population places.

A phase of the medical care problem for these rural and sparsely settled regions that do not possess the population or resources to enable a physician to properly maintain himself and his family, brings up the thought that through subscription by local citizens (or through single local, or perhaps, joint local, state and federal coöperation), it may be possible to establish subsidies that could be paid to a physician who would go in and practice in such a district. That plan is in operation in some Canadian communities.

The costs of such a subsidy procedure—in the limited number of places where the same may be indicated,—would be as nothing, compared to the millions upon millions of dollars of federal funds that would be needed under a compulsory and socialized, political medicine plan, such as would be created by the Wagner-Murray-Dingell bill, S. 1606, presented to Congress on November 19, 1945.

\* \* \*

**(2) Hospital and Health Centers in Urban and Rural Environments.**—By their very nature, hospitals are expensive expressions of modern-day American civilization. In one sense, they are hotels for sick and injured people, operating in part as such; but with much greater costs in capital investment and maintenance, due to expensive laboratory and other equipment, and larger personnel, such as technicians, trained dietitians, and professional nurses on 8 hour shifts.

In metropolitan areas, private hospitals in the past have usually come into being when sufficient public need, demand and support have been given. In such densely populated places, public as well as private hospitals of high standard are generally maintained. Through the opportunities given members of attending staffs to meet without great loss of time, these hospitals practically become health centers, their hospital staffs working with local medical societies and public health administrators to promote excellent work in both preventive and curative medicine.

However, to erect suitable buildings and try to maintain modern hospital structures in places where only a small number of physicians and professional nurses are in practice and where philanthropic or tax moneys are not available, would lead to nothing else than disaster. Indeed, such ill-considered attempts would change the existing system into something that would create not better, but poorer medical care. The Do-Gooder Reformers who advocate their vagaries on medical care, should take time for some quiet thinking before they expound their theoretical visions. What some of these propagandists need, above all else, is less cheap pseudo-altruism, and more common sense realism.

\* \* \*

**(3) The Physician.**—The promoters of socialized medical plans, as a class, seem to derive

special joy in assailing organized medicine (American Medical Association, State Medical Societies, County Medical Units). By them, the 120,000 well educated and professionally trained Doctors of Medicine who are members of these organizations are looked upon as a group of reactionaries, bound by union or worse rules, and not daring to speak up in opposition to the officers, whom they have elected (democratically) to be their leaders. What a misrepresentation!

Now, let us ask, who are these physician men and women who have taken upon themselves to become disciples of the healing art? The great majority either hold liberal arts degrees or have received equivalent education. In addition they have pursued courses of professional training covering four years, to which have been added one or two additional years of hospital internship and residency experience. All this, at a cost to each of them of some of the best years of their lives spent in earnest study, and at a money price of about ten to twenty thousand dollars.

As individuals with such educational backgrounds, they hope to make similar opportunities available for their children. In cities, they can obtain such. In isolated or sparsely settled places, such opportunities at times do not exist. Therefore, there is a natural reluctance on the part of many physicians to establish themselves in practice in sparsely settled communities. Yet, by inference, the reformers hold that physicians should and must be so provided. Query: How can this be accomplished, legally?

For, by what American law can a law-abiding individual be forcibly taken from one community by the government, and made to settle in some other community? There is no such statute. How then, will the Do-Gooder visionaries secure the physicians to go to out-of-the-way places, unless subsidy plans or equivalent measures to provide for decent compensation are first provided?

If a beginning must be made to bring about a migration of physicians, from metropolitan or other areas to less settled communities, why should not the Do-Gooder Reformers first work out practical plans along lines noted above, instead of presenting their expostulations on behalf of visionary and non-practical schemes? These propagandists might better spend some of their time in constructive thinking instead of loose talking.

\* \* \*

**In Summary.**—In the above have been charted a few of the practical problems that should be considered when President Truman's message to Congress and Wagner-Murray bill S. 1606, come up for consideration.

No man can prove that individually and collectively, members of the medical profession have not as much love for their human fellows as any other profession or group.

Since Doctors of Medicine have more practical experience concerning medical practice and needs, it follows that the opinions of physicians thereon should be worthy of serious and special considera-

tion. Not so, presumably, in the opinion of the Do-Gooder Reformers, who have been so busy in the drafting of sickness insurance laws in the construction of which, organized medicine through its national, state and local units is nearly always forgotten!

Hence, there is no other course for the medical profession to follow, than to give battle to the supposed reformers, who, through revolutionary, impractical schemes, would establish a compulsory political bureaucracy designed to supervise political medical care. The institution of such a system would destroy the fine advances that have been made through scientific medicine, under the evolutionary system of medical practice now existing in the United States.

As loyal Americans, the physicians of the United States will fight to preserve for their lay fellow citizens, those forms of medical practice that have given to our country the lowest morbidity and mortality rates of any civilized nation comparable to our own in diversity of domain and industrial, agricultural and welfare environments.

To do less, would be lacking in loyalty to our people and our profession.

## EDITORIAL COMMENT†

### CARDIOTOXIN INHIBITORS

Isolation of a hitherto unsuspected protective internal secretion from the heart muscle is reported by Cantoni and Bernheimer<sup>1</sup> of the Department of Pharmacology and Bacteriology, New York University College of Medicine. The new myocardial internal secretion will neutralize (or otherwise inhibit) multilethal doses of streptococcus toxin, and toxic products from certain other pathogenic bacteria.

Discovery of the new myocardial protective hormone was a by-product of a study of the pharmacological action of various bacterial toxins on the isolated frog's heart.<sup>2</sup> *Streptococcus pyogenes* was grown in mass culture in Bernheimer's<sup>3</sup> synthetic medium. After 20 hours growth at 35°C. the fluid culture was refrigerated over night, then centrifuged. The resulting supernatant fluid was concentrated 300-fold by repeated evaporation and repeated dialysis against saturated or half-saturated ammonium sulfate. This was followed by dialysis against running tap water. The resulting dialyzed concentrate was found to be strongly hemolytic for human r.b.c., its average hemolytic titer being 100,000 Bernheimer units<sup>4</sup> per cc.

The concentrate was diluted 25 times with Ringer's solution containing cystein in a concentration of 1:1000 to serve as an activator. The

activated dilute concentrate was then administered to an isolated frog's heart by means of a Fühner cannula, and allowed to remain in the heart for 23 minutes. No toxic reaction was recorded other than a slight increase in systolic amplitude. In other tests, the activated dilute concentrate was removed from the heart at the end of 5 minutes, and the heart washed twice during the next 10 minutes with Ringer's solution. A second dose of dilute concentrate identical with the first was then introduced into the Fühner cannula. Within 30 seconds decreased relaxation of the ventricle was recorded, increasing to a complete systolic contracture and standstill by the end of 90 seconds. In some unknown way contact with the apparently non-toxic first dose of streptococcus concentrate "sensitized" the heart so that the second dose of the same concentrate produced a rapidly lethal effect.

Quantitative studies showed that this terminal toxicity could not be accounted for as a simple summation of two subthreshold doses of streptococcus toxin. It was further found that fluid removed from the ventricular cavity 5 minutes after instillation of the first dose contained sufficient streptococcus "inhibitor" to neutralize from 5 to 10 lethal doses of the streptocardiotoxin if given to a previously sensitized heart. As a result of release of this inhibitor the heart muscle was presumably depleted of its normal chemical defense, and was thus rendered hypersusceptible. Preliminary tests suggest that this inhibitor will also neutralize type II pneumococcus hemolysin and *Cl. welchii* theta-toxin.<sup>5</sup>

The antitoxic action of this inhibitor was confirmed on mice. It was found that 0.5 cc. of a 1:25 dilution of activated streptococcus concentrate injected intravenously would kill 16-20 gram mice within 5 minutes. Of 17 mice which received this dose plus 0.125 to 0.50 cc. of inhibitor fluid, 15 survived longer than 5 minutes and 10 survived indefinitely. Of 11 control mice which received the same toxin but no inhibitor, all 11 died within 5 minutes.

The inhibitor is non-dialysable through a cellophane membrane, is kokostable and chloroform-soluble. It is presumably a lipid, having no chemical similarity with a humoral antibody. If confirmed, these facts suggest that the New York pharmacologists have opened up a new field of immunologic research, whose practical results may in time rival those from conventional antibodies.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.



### PENICILLIN THERAPY OF RABBIT SYPHILIS

In a posthumous paper, Raiziss<sup>1</sup> of the Dermatological Research Laboratory, Philadelphia, summarizes his accumulated experimental evidence as to the therapeutic value of penicillin in the treatment of experimental testicular syphilis in rabbits. In a preliminary test<sup>2</sup> he had previously reported that intramuscular injection of 2,500 Oxford units of penicillin sodium in aqueous solution twice daily for 8 consecutive days, rendered the testicles apparently free from spirochetes by the 14th day, and led to apparently complete healing by the 42nd day. Slightly better results were obtained by injecting 5,000 Oxford units in peanut oil once daily for 8 consecutive days, spirochetes disappearing by the 8th day, with apparently complete healing by the 35th day.

Raiziss recognizes that return of the testicles to apparently normal following antisyphilitic treatment does not constitute proof of a complete cure. The popliteal lymph nodes of the treated rabbits were therefore removed 100 to 115 days after the testicles had become apparently normal, and tested for spirochetes by intratesticular transfer into normal rabbits. In all cases, such transfer gave negative results, indicating a complete cure.

Since making his preliminary report, other syphilitic rabbits have been given larger doses, such as 5,000 units per Kg. of body weight in peanut oil, twice daily for 8 consecutive days, or a total of 80,000 Oxford units during the 8-day period. These rabbits were freed from spirochetes and returned to normal sooner than in the first tests, late popliteal transfer indicating a complete cure. From these more favorable results, Raiziss recommends that for a 60 Kg. patient, 300,000 Oxford units in peanut oil should be injected intramuscularly twice daily for a period of 8 days, a total of 4,800,000 Oxford units for the 8-day period. He believes this method is simpler and would give more satisfactory results than the conventional continuous drip method.

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#### Medical Group Union Formed in Los Angeles

The CIO State, County and Municipal Workers announces that it has unionized the Los Angeles County Bureau of Medical Service and that it has plans for a joint union-management committee to operate within the bureau.

About 100 persons work in the bureau which is headed by Mrs. Myrtle Silver. Its employees determine whom the County of Los Angeles shall admit to its General Hospital and various institutions for county aid. They also advise the families.

The union announced also that it is proposing that its members be required to work only 40 hours instead of 48 hours, but that they be paid the same for the shorter week.

H. S. Jung, regional director of the CIO union, said he has notified A. J. Will, head of the Los Angeles County Department of Charities.—*Los Angeles Times*, November 30.

### Governor Warren Will Call Special Session

Governor Warren on November 9, disclosed that he would call a special session of the Legislature to deal with postwar problems some time before federal funds for maintenance of child care centers expire.

While no date was set, one ranking state official said the Governor was considering issuing the call for January. (Date has been set for January 7.)

### California State Health Plan Debated

Arguments similar to those heard when the proposal was turned down by the Legislature were voiced on November 15, when Governor Earl Warren's compulsory health insurance plan was debated at the first meeting of a State senate interim committee.

William T. Sweigert, executive secretary and spokesman for the Governor, declared that California's failure to take constructive action towards an adequate medical care program will invite the alternative of highly centralized Federal control.

Mr. John Hunton, executive secretary of the California Medical Association, held that "the proper quality and quantity of medical service can be better accomplished by voluntary means than by compulsion."

The committee that heard the arguments is headed by Senator Byrl Salzman, who announced the appointment of Dr. Russell V. Lee of Palo Alto as its research consultant and advisor.

Mr. Sweigert told the session that a plan such as that advocated by Governor Warren is the only method of overcoming "unpredictability of costs" and of providing adequate medical and hospital care for the average Californian.

He appealed to all elements of the medical profession to "get together" on a sound program and to cease regarding the Governor's plan as "socialized medicine."

Contending that voluntary systems are best, Mr. Hunton and Dr. P. K. Gilman, Medical Association president, said steps were being taken to inform the public of existing voluntary systems and induce greater enrollment.

Professor Samuel C. May of the University of California predicted that doctors, insurance carriers and others opposing health insurance will join in a "concentrated attack" on all such proposals.

Speaking for the State Federation of Labor, Charles P. Scully declared the Federation is agreed there "obviously is a great need for a program."

Mrs. George H. Hoxsie submitted a statement of the policy of the California League of Women Voters, endorsing a program closely paralleling that sponsored by the Warren Administration.

### Assembly Committee on Health Plan Meeting

Public health insurance programs were under discussion on November 9, at the opening session of a two-day meeting of the State Assembly interim committee on health care.

Committee members were meeting with representatives of the Blue Cross and the California Physicians' Service in the State Railroad Commission's courtroom.

Members of the two health associations presented their views on insurance programs to the committee, which recommended a plan for state public health insurance to the Legislature after hearing testimony of health groups in cities throughout the state.

The committee, which was created by the last Legislature to investigate public health insurance programs after the defeat of the compulsory payroll deduction plan sponsored by Governor Warren, is under the chairmanship of Ernest Geddes, Pomona assemblyman.

## ORIGINAL ARTICLES

## Scientific and General

## TECHNIQUE OF CAROTID SINUS STIMULATION\*

JOHN MARTIN ASKEY, M. D.

*Los Angeles*

**P**AROXYSMAL auricular tachycardia is encountered sooner or later in every general physicians practice, and constitutes a minor or major cardiac emergency depending upon the condition of the heart itself and the duration of the tachycardia. It responds to various treatments, often stopping spontaneously. Pressure over the carotid sinus is one of the measures used most frequently in stopping such attacks. The success of this maneuver depends upon eliciting a strong reflex vagal cardiac effect by mechanical stimulus of the nerve filaments in the carotid sinus. There are two requisites for the maneuver to be effective. First, precisely to locate the carotid sinus, second, to apply adequate stimulation. It is probable that many failures to stop paroxysmal auricular tachycardia are due to failure properly to locate the sinus, inasmuch as pressure over the common carotid artery below the sinus has no effect. There are few detailed descriptions of the application of this maneuver, and many medical students and physicians, we believe, are unfamiliar with the details of the technique.

## PROCEDURE

The technique we use is as follows:

The patient sits upright in bed or in a chair. The chin is elevated to make the carotid artery more readily palpable. The patient is instructed to hold the stethoscope over the apex of the heart with the right hand. (Fig 1.) Taking his position in front and to the left of the patient, the doctor applies his right hand to the left side of the patient's head. With two or three fingers of his left hand, he then locates the pulsation of the right common carotid artery and follows it up the neck to about the level of the upper border of the thyroid cartilage, where the carotid sinus may be felt as a bulge at the bifurcation of the common carotid artery. (Fig. 2.) If the bulge is not felt definitely, the point of greatest pulsation usually will be the correct site. With the fingers of the left hand, pressure is then firmly made over this bulge backward and medially firmly enough completely to compress the artery. A slow vertical and rotary massage over the sinus is employed in order to stimulate the maximum number of nerve filaments. Adequate pressure is necessarily firm but not severe. It is not unusual for the patient to wince from the pressure. If the sinus is correctly located and massage is adequate, the tachycardia usually will terminate abruptly after a few seconds. It is not more effective, nor is it wise, we believe, to press longer than 5 to 10 seconds at a time. If the tachycardia does not stop after pressure on the right side, pressure may be made over the left carotid sinus, although it is seldom successful if pressure over the right carotid sinus fails.

## COMMENT

By the above method, the carotid sinus is usually located readily, counter-support of the head to allow firm



Fig. 1.—Position of patient and examining physician.

pressure is supplied, continuous auscultation of the heart to indicate the exact moment of cessation of the tachycardia is possible, and observation of the patient is permitted. Some advise standing behind the patient while applying pressure. It is always wise, we believe, to observe the patient's face at any time carotid sinus pressure is employed. Besides syncope which results from bradycardia or hypotension, sudden syncope due to a direct cerebral effect is also mediated through the carotid sinus nerves. Such a syncopal reaction usually occurs abruptly without any preceding bradycardia and is usually

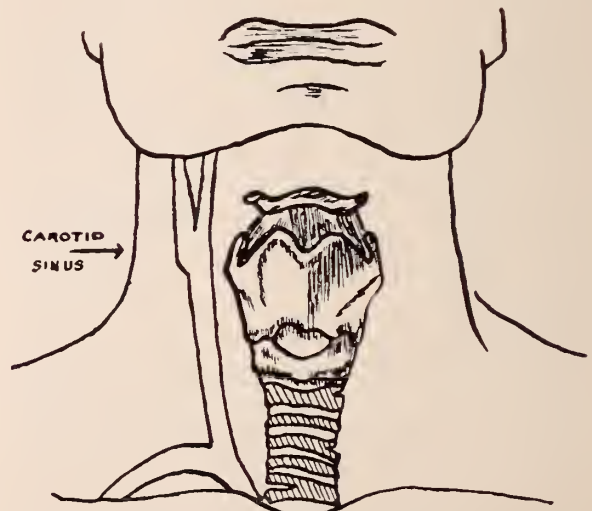


Fig. 2.—Topographical location of carotid sinus.

\* From the Department of Medicine, University of Southern California School of Medicine.

Acknowledgment of assistance in the preparation of this paper is made to Dr. Joseph A. Pollia.



preceded by sudden facial blanching. Such a reaction is rare in paroxysmal supraventricular tachycardia, but may occur and one is always prepared if the technique includes standing in front of the patient. In case of a syncope reaction, the hands are in ready position to hold the patient and to lower him into a recumbent position.

#### CONCLUSION

Carotid sinus stimulation also has a place in the differentiation of arrhythmias.<sup>1</sup> It has been used to identify the hypersensitive carotid sinus syndrome, and as a routine in complete neurological examinations. Its employment for the latter purpose in the middle aged or elderly individual with arteriosclerosis should be cautiously weighed. Untoward cerebral accidents have occurred<sup>2</sup> and although these are fortunately very rare, the possibility should be recognized and should enter into the consideration of the indications and contraindications for the use of the maneuver.

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## VARIATIONS IN SIZE OF THE HUMAN STOMACH\*

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San Francisco

TEXT books provide few and sometimes conflicting data regarding the size of the human stomach. Cunningham's Textbook of Anatomy contains the statement, "probably no organ in the body varies more in size within the limits of health than the stomach"; however, it is not clear whether "size" refers to weight or capacity, post mortem measurements of which are recognized to be misleading. Specific records of stomach size are not common, but several have been reported. All deal either with weight of the organ or with its capacity. Ross<sup>1</sup> reports the normal stomach capacity as 1-2 liters and the normal weight as 125 to 175 grams. Reed<sup>2</sup> notes the "average capacity" as 1600 to 1700 cc. and the normal weight range as 113.4 to 141.75 grams.

#### POST MORTEM MEASUREMENTS

Measurements of the capacity of the stomach post mortem are not reliable because of the impossibility of standardizing the degree of distension of the organ. Differences in the amount of muscle, rigor mortis, and other post mortem changes may influence the distensibility. A more reliable index of stomach size is the total area of the mucosa after it is spread so that all folds are removed. In stomachs which are not distended, the mucosa, because of its folds, has an area greater than that of the muscular wall. When the latter is stretched the mucosal folds are progressively flattened until they disappear and the mucosal surface is uniformly parallel to that of the muscle. This disappearance of the mucosal folds on stretching of the stomach is an end point which can be recognized readily. Although most methods of stretching cause some further tension to be applied to those portions

of the mucosa, where folds are absent or disappear early, this does not lead to much increase in area because gastric mucosa can be stretched only slightly after the folds are flat, and will tear before there is much increase in area. This standardized stretching procedure is easily accomplished with the excised opened stomach and such a method has been used in this study.

One hundred and twenty-six human stomachs obtained at autopsy have been measured. Most of the specimens were obtained within six hours of the time of death, and none has been included in which post mortem digestion of the mucosa has been more than superficial. The stomachs have been opened along the greater curvature and have been pinned to a board in the stretched position before fixation in 4 per cent aqueous formaldehyde. After fixation, maps have been prepared by tracing the outline of each specimen on paper, and the areas of gastric mucosa have been measured from the maps by means of a planimeter. Average values for stomach mucosal area obtained in this way are 843 sq. cm. for males and 763 sq. cm. for females.

All of the stomachs were weighed after formalin fixation and removal of the attached ligaments and masses of fatty tissue, and the value was corrected later by subtracting the weights of the attached portions of esophagus and duodenum, which were removed after histological sections had been prepared. The average stomach weight was 165 grams in males and 150 grams in females. Fig. 1 shows the relation between the mucosal area and the stomach weight in the individual cases. The greater weight of those stomachs having large mucosal areas indicates that differences in the latter are not due merely to variation in degree of stretching. Preliminary observations show the greatest thickness of mucosa in the stomachs with large areas, so it is apparent that the mucosal area provides a rough index of the quantity of mucosal tissue present.

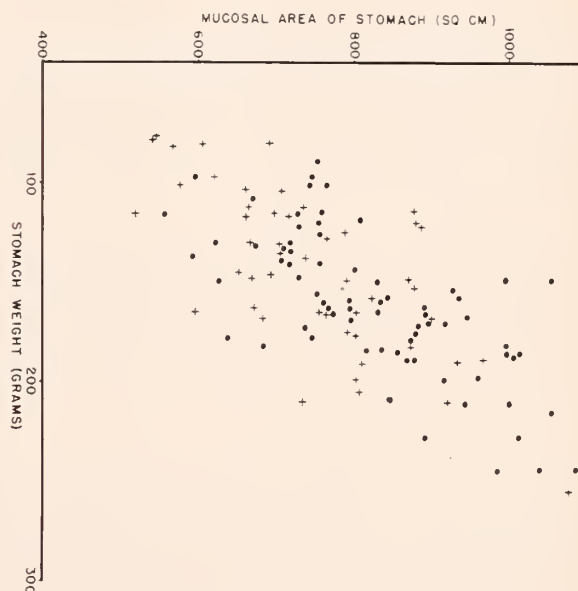


Chart 1.—Differences in Size of the Human Stomach (based on measurements of 126 stomachs).

Solid circles represent males; crosses represent females. One additional stomach from the series (area 1536 sq. cm. and weight 453 gms.) was so much larger than the others that it was not included in this chart.

The extreme values for mucosal area in this series are 520 and 1536 sq. cm., and the range of stomach weight is from 77 to 453 grams. These represent variations of three and six fold respectively. The differences are not related to age of the patients, which ranged from 19 to 83 years.

\* Read before the Section on Pathology and Bacteriology at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

From the Department of Pathology, Stanford University School of Medicine, San Francisco.

Similarly, body height and body weight have shown no close correlation with stomach size. The sex difference recorded above is no greater than sex differences in weights of other organs, and is considerably smaller than differences within each sex group. Therefore, it has been concluded that some other influence is largely responsible for determination of stomach size.

#### COMMENT

It is possible that functional factors may contribute to stomach size. This may bear a relationship to work performed similar to that suggested by Addis and co-workers<sup>3,4</sup> for the heart, kidney, liver, and gastrointestinal tract of experimental animals, but it has been impossible to demonstrate such an influence since no reliable information is available concerning the eating habits of the patients in this series. The stomach size bore no apparent relation to the nutritional state of the individuals.

Many diseases are represented in this series of cases, but most do not occur with sufficient frequency to permit valid conclusions regarding their relation to stomach size. No constant relationship to specific disease has been observed. Cases of carcinoma of the stomach, which greatly modifies the stomach size, have not been included in this series. Other gastric lesions were not obviously related to the size of the organ. Several stomachs exhibiting gastric ulcer showed little deviation from the average. As a group, the cases showing the changes of so-called chronic atrophic gastritis had normal sized stomachs, although two of four cases of pernicious anemia with severe mucosal changes had areas of 542 and 546 sq. cm. respectively. These were two of the three smallest stomachs in the series.

Two other groups of cases showed variations from the average stomach size which can only be mentioned because, due to the small number of cases, the significance of the differences is questionable. Stomachs from eight patients with diabetes mellitus had an average mucosal area which was 23 per cent greater than that of non-diabetic patients. In 17 stomachs from cases of chronic or healed duodenal ulcer, the average area was 9 per cent greater than that of cases without duodenal ulcer. There was no anatomical obstruction of the pylorus in any case. Clarification of the reasons for these apparent differences will require further observation.

#### SUMMARY

Measurements of mucosal area and total weight have been made in 126 human stomachs obtained at autopsy. Variations in stomach size are significant but cannot yet be explained. Differences in sex, age of patients, or body size do not account for the differences in the stomachs. Possible relationships to other conditions have been discussed.

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This government, with its institutions, belongs to the people who inhabit it. Whenever they shall grow weary of the existing government, they can exercise their constitutional right of amending it, or their revolutionary right to dismember or overthrow it.

—Abraham Lincoln, *Speech*, at first Republican State Convention in Illinois, 1856. Quoted by Theodore Roosevelt in address before Ohio Constitutional Convention, Columbus, February, 1912.

## ANATOMICAL DEMONSTRATION OF THE ANOVULATORY MENSTRUAL CYCLE\*

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IN 1923, George W. Corner,<sup>1</sup> and in 1927, Corner,<sup>2</sup> Carl G. Hartman,<sup>3</sup> and Edgar Allen<sup>4</sup> reported that recurrent hemorrhage from the healthy uterus occurred in the macacus rhesus without ovulation and in the absence of premenstrual changes in the endometrium. Corner<sup>2</sup> suggested the possibility that a similar type of menstruation might be found in women. Since these original publications, a large body of information on the anovulatory cycle of the monkey has been carefully accumulated.<sup>5,6</sup> Using the castrated monkey as experimental animal, Edgar Allen<sup>4</sup> demonstrated that discontinuation of estrogen treatment would result in menstruation and his observations became the basis for the estrin deprivation theory of menstruation. The similarity of the bleeding phenomena between the anovulatory and ovulatory menstruation was further emphasized and rather convincingly demonstrated in the experiments of Markee<sup>7</sup> who studied the bleeding mechanism in intraocular endometrial implants in both conditions.

In women, a small number of cases have been reported in which the examination of the pelvic organs free of pathology offered sufficient proof to make the diagnosis of an anovulatory cycle.<sup>8,9,10</sup> On the other hand, most of the textbooks on this and related subjects state that anovulatory cycles probably occur much more frequently and the condition has become a rather well recognized endocrine entity.<sup>11,12</sup> Statements as to the frequency of this type of menstrual cycle are of necessity vague, although clinicians usually point out that the incidence is probably higher during the first years following the menarche as well as during the period preceding the menopause. However, anovulatory cycles may be found at any time during the reproductive period of life. (Example. Case 8 of Bartelmez.)

#### REPORT OF CASE

The present report is of a 12 year old girl who came to autopsy 26 hours after a spontaneous intracerebral hemorrhage with no history of trauma. The girl had been well except for whooping cough at 5 and chicken pox and mumps between the ages of 6 and 8. Her menarche was 4 months prior to death, and four menstrual periods had been regular and without pain. Her last menstrual period was one week before death.

At autopsy, the girl was well developed including the secondary sex characteristics. She weighed 105 pounds and was 5 feet 2 inches tall. The brain showed a large defect in the frontal and parietal lobes filled with blood. The hemorrhage had occurred from one of multiple malformations in the wall of the cortical branches of the left middle cerebral artery. There was no evidence of trauma or previous hemorrhage. The remaining tissues and organs were normal although several sections taken from the aorta showed multiple microscopic areas of medial degeneration. Examination of the genital organs revealed the following: The uterus was normal, the length of the uterine body approximately equalled that of the cervical canal and cervix. The endometrium was regular, thin, and firm, measuring 1 mm. in thickness. The tubes were normal. The surfaces of the ovaries were smooth except for a small dimpled area in the left ovary. On sectioning, both ovaries contained numerous small cysts measuring up to 0.7 cm. in diameter. The left ovary contained a small yellowish structure which proved to be an old corpus luteum on histologic examination. The cysts were lined partly by healthy appearing granulosa cells, partly by granulosa cells showing karyorrhexis, and partly by theca interna cells. The cortical zone contained numer-

\* Read before the Section on Pathology and Bacteriology, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

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ous primordial follicles and a small number of developing Graafian follicles. The predominant cell type in the anterior hypophysis was the granulated acidophil interspersed with small groups of granulated basophiles. The basophiles were somewhat more numerous at the periphery of the hypophysis.

## COMMENT

This case demonstrates several features which permit the diagnosis of the anovulatory cycle. The patient falls in the age group in which this type of menstrual cycle supposedly is rather frequent, the menarche having been four months and one week prior to death. The history of regularly spaced menstrual periods and the finding of only one corpus luteum indicates that three out of the four periods occurred without preceding ovulation and that ovulatory and anovulatory cycles may follow in succession. In the absence of any pelvic pathology, including evidence of hyperplasia of the endometrium which is more common in the older age group,<sup>12</sup> it seems safe to assume that our patient had regularly recurrent hemorrhages from a healthy uterus without ovulation and corpus luteum formation.

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## INTROSPECTION AND THE ORBITAL CORTEX\*

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AS the subject of cerebral cortical localization of function develops, each few years' innovations show new obstacles falling before the attacks of students. As would be expected, those functions which most definitely have appeared to be psychological have been the last to be physiologically understood. It now has become established that the orbital cortex, chiefly areas 11 and 12 of Brodmann, contains the neurograms of the cortical representative of personality, character and introspection—in short, patterns of the "self."

The entire neurogram system of personality and self is constituted of a hypothalamic, a thalamic and two cortical portions, a cingulate and an orbital component. In the lower animals there is no orbital fraction and the animals show practically no cortical modification of the instinctive personality. The anthropoids do have some orbital cortex but it is relatively rudimentary. Animals in general are spontaneous; they live for the moment; they do not show any signs of introspection and are apparently unconcerned with their origin or destiny. It would be both interesting and instructive, in fact of clinical value, if one could determine what cortical structure and what corresponding cerebral function distinguish man from animals.

The researches of von Bonin<sup>1</sup> and of others doing cytoarchitectonic work have shown during the last few years that primates have areas of Broca which are well developed. In harmony with this, but as an entirely independent observation, Sanderson<sup>2</sup> has found that the gorilla in his natural haunts has "as many speech sounds and combinations as man." We are therefore compelled to conclude that speech is not entirely a human capacity.

## COMPARISON OF HUMAN AND PRIMATE BRAINS

Comparison of human and primate brains shows clearly that the great difference in the cortex, as one ascends the scale, is in the size of the frontal lobes. Man has far more frontal cortex, even in proportion to total brain volume, than has the gorilla. Such an observation, however, proves nothing unless the situation is more clearly analyzed.

Analysis reveals that the gorilla has areas 6, 8, 9, 10, 44 and 47 in about as large a proportion for its brain as the human being possesses. These areas are concerned with movements, coordination and speech. But the orbital cortex, which is apparently concerned only with self, the relation of the individual to the environment, with introspection and personality, is particularly small in the gorilla and still smaller in the orangutan and chimpanzee. And it is exactly in these respects that man is superior. Comparison of gorilla brains with human brains in lateral silhouette shows the average human to be superior to that of the gorilla brain, but such a simple comparison is fallacious. The entire gorilla brain weighs less than half the average human brain. (Not more than 100 gorilla brains have been studied and it is quite possible that much larger ones do occur, but large human brains also are known.) The final correlation would have to be made by cytoarchitectonic comparisons. The general impression of such an authority as Tilney<sup>3</sup> is that the human brain is far superior.

Another criterion commonly used but exceedingly fallacious (in the sphere of function) is that of knowledge of paternity. All students are agreed that animals do not possess such knowledge; the male gorilla certainly does not know, or suspect, that he fathers the young. However, the lowest forms of human being also lack knowledge of paternity. Malinowski<sup>4</sup> has shown for the Trobriand Islanders and Daisy Bates<sup>5</sup> for the Australian aborigines that they do not know, and cannot be convinced, that children result from coitus. They believe that spirits cause pregnancy and that coitus is exclusively for pleasure. Some human beings, therefore, are not above the gorilla in such knowledge, but they are far superior in having thought about it and in having arrived at a belief which satisfies them.

## SYNDROME OF THE ORBITAL CORTEX

There are in the literature about a dozen cases of accidental destruction of both orbital cortices in the adult human being. These cases show a typical syndrome which should enable the physician to establish the diagnosis. Case reports can be found in the large work of Kleist.<sup>6</sup> When the lesion is unilateral the matter is very uncertain because of the ability of the remaining cortex to carry on. Patients with bilateral lesions show character changes the basic element of which is the loss of self critique. But more fundamental than self critique is introspection, because one does not criticize what one does not inspect. The patients accept no discipline and if it is forced upon them they do not profit by it. They have no consideration for others, no self respect. As they have no self respect they have no pride and are not easily insulted. Kind advice has no lasting result. The patients characteristically lie and steal and have violent outbursts.

This syndrome has some resemblance to that of tumors

\* Read before the Section on Neuropsychiatry, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

of the third ventricle. But lesions of that site, which affect the hypothalamus and thalamus, cause their syndrome by affecting the basilar end of the neuronal system underlying personality. Hence the cortical elements are unaltered and the syndrome is different. The patients are forgetful and somewhat stupid. However, in any syndrome suggesting orbital cortex lesion it is well to exclude neoplasm of the third ventricle.

#### SUMMARY

The orbital cortex and its connections with the diencephalon are much more highly developed in man than in the primates. Its proportionately much greater volume means something in this connection but size alone does not give a crucial answer. It is the far more highly developed organization of this area which distinguishes man from animals. A clinical syndrome is outlined which makes recognition of a lesion of the orbital cortex possible. The keynote of the syndrome is loss of capacity for introspection.

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### PRESIDENT HARRY S. TRUMAN'S FEDERAL HEALTH INSURANCE PLAN\*

Washington, Nov. 19.—(AP.)—President Truman's message to Congress on a national health program follows, in part:

(A)—In my message to the Congress of September 6, 1945, there were enumerated in a proposed economic bill of rights certain rights which ought to be assured to every American citizen.

One of them was: "The right to adequate medical care and the opportunity to achieve and enjoy good health." Another was the "right to adequate protection from the economic fears of . . . sickness."

Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have the protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.

(B)—The people of the United States received a shock when the medical examinations conducted by the selective service system revealed the widespread physical and mental incapacity among the young people of our nation. . . .

We had had prior warnings from eminent medical authorities and from investigating committees. The statistics of the last war had shown the same condition. But the Selective Service System has brought it forcibly to our attention recently in terms which all of us can understand.

\* For convenience of readers of CALIFORNIA AND WESTERN MEDICINE, when referring to the almost complete text of the message on a National Health Program submitted to the 79th Congress by Harry S. Truman, President of the United States, the text as here appearing has been marked by letter reference in brackets and with arrows. Additional paragraphs and paragraph lettering have also been inserted.

For editorial comment in current issue of CALIFORNIA AND WESTERN MEDICINE, see pages 253-264.

#### DRAFT RECORD

As of April 1, 1945, nearly 5,000,000 male registrants between the ages of 18 and 37 had been examined and classified as unfit for military service. The number of those rejected for military service was about 30 per cent of all those examined. The percentage of rejection was lower in the younger age groups and higher in the higher age groups, reaching as high as 49 per cent for registrants between the ages of 34 and 37.

In addition, after actual induction, about a million and a half men had to be discharged from the Army and Navy for physical or mental disability, exclusive of wounds; and an equal number had to be treated in the armed forces for diseases or defects which existed before induction.

(C)—Among the young women who applied for admission to the Women's Army Corps there was similar disability. Over one-third of those examined were rejected for physical or mental reasons.

These men and women who were rejected for military service are not necessarily incapable of civilian work. It is plain, however, that they have illnesses and defects that handicap them, reduce their working capacity, or shorten their lives. . . .

It is not so important to search the past in order to fix the blame for these conditions. It is more important to resolve now that no American child shall come to adult life with diseases or defects which can be prevented or corrected at an early age.

Medicine has made great strides in this generation, especially during the last four years. We owe much to the skill and devotion of the medical profession. In spite of great scientific progress, however, each year we lose many more persons from preventable and premature deaths than we lost in battle or from war injuries during the entire war.

We are proud of past reductions in our death rates. But these reductions have come principally from public health and other community services. We have been less effective in making available to all of our people the benefits of medical progress in the care and treatment of individuals.

#### MANY DEPRIVED

(D)—In the past, the benefits of modern medical science have not been enjoyed by our citizens with any degree of equality. Nor are they today. Nor will they be in the future—unless government is bold enough to do something about it.

People with low or moderate incomes do not get the same medical attention as those with high incomes. The poor have more sickness, but they get less medical care. People who live in rural areas do not get the same amount or quality of medical attention as those who live in our cities.

Our new economic bill of rights should mean health security for all, regardless of residence, station, or race—everywhere in the United States.

(E)—We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation.

#### FIVE PROBLEMS

There are five basic problems which we must attack vigorously if we would reach the health objectives of our economic bill of rights.

(F)—I—The first has to do with the number and distribution of doctors and hospitals. One of the most im-



portant requirements for adequate health service is professional personnel—doctors, dentists, public health and hospital administrators, nurses and other experts.

The United States has been fortunate with respect to physicians. In proportion to population it has more than any large country in the world, and they are well trained for their calling. It is not enough, however, that we have them in sufficient numbers. They should be located where their services are needed. In this respect we are not so fortunate.

The distribution of physicians in the United States has been grossly uneven and unsatisfactory. Some communities have had enough or even too many; others have had too few. Year by year the number in our rural areas has been diminishing. Indeed, in 1940, there were thirty-one counties in the United States, each with more than a thousand inhabitants, in which there was not a single practicing physician. The situation with respect to dentists was even worse.

One important reason for this disparity is that in some communities there are no adequate facilities for the practice of medicine. Another reason—closely allied with the first—is that the earning capacity of the people in some communities makes it difficult if not impossible for doctors who practice there to make a living.

(G)—The demobilization of 60,000 doctors, and of the tens of thousands of other professional personnel in the armed forces is now proceeding on a large scale.

#### SPEED NEEDED

Unfortunately, unless we act rapidly, we may expect to see them concentrate in the places with great financial resources and avoid other places, making the inequalities even greater than before the war.

Demobilized doctors cannot be assigned. They must be attracted. In order to be attracted, they must be able to see ahead of them professional opportunities and economic assurances.

(H)—Inequalities in the distribution of medical personnel are matched by inequalities in hospitals and other health facilities. Moreover, there are just too few hospitals, clinics and health centers to take proper care of the people of the United States.

About 1,200 counties, 40 per cent of the total in the country, with some 15,000,000 people, have either no local hospital or none that meets even the minimum standards of national professional associations. The deficiencies are especially severe in rural and semirural areas and in those cities where changes in population have placed great strains on community facilities. I want to emphasize, however, that the basic problem in this field cannot be solved merely by building facilities. They have to be staffed; and the communities have to be able to pay for the services. Otherwise the new facilities will be little used.

(I)—II—The second basic problem is the need for development of public health services and maternal and child care.

The Congress can be justifiably proud of its share in making recent accomplishments possible. Public health and maternal and child health programs already have made important contributions to national health. But large needs remain. Great areas of our country are still without these services. This is especially true among our rural areas; but it is true also in far too many urban communities.

Although local public health departments are now maintained by some 18,000 counties and other local units, many of these have only skeleton organizations, and approximately 40,000,000 citizens of the United States still live in communities lacking full time local public health

service. At the recent rate of progress in developing such service, it would take more than a hundred years to cover the whole nation.

If we agree that the national health must be improved, our cities, towns and farming communities must be made healthful places in which to live through provision of safe water systems, sewage disposal plants and sanitary facilities. Our streams and rivers must be safeguarded against pollution. In addition to building a sanitary environment for ourselves and for our children, we must provide those services which prevent disease and promote health.

Services for expectant mothers and for infants, care of crippled or otherwise physically handicapped children and inoculation for the prevention of communicable diseases are accepted public health functions. So, too, are many kinds of personal services such as the diagnosis and treatment of widespread infections like tuberculosis and venereal disease. A large part of the population lacks many or all of these services.

Our success in the traditional public health sphere is made plain by the conquest over many communicable diseases. Typhoid fever, smallpox and diphtheria—diseases for which there are effective controls—have become comparatively rare. We must make the same gains in reducing our maternal and infant mortality, in controlling tuberculosis, venereal disease, malaria and other major threats to life and health. We are only beginning to realize our potentialities in achieving physical well-being for all our people.

(J)—III—The third basic problem concerns medical research and professional education. . . .

#### RESEARCH AND EDUCATION

We have long recognized that we cannot be content with what is already known about health or disease. We must learn and understand more about health and how to prevent and cure disease.

#### URGES RESEARCH

Research—well directed and continuously supported—can do much to develop ways to reduce those diseases of body and mind which now cause most sickness, disability, and premature death—diseases of the heart, kidneys and arteries, rheumatism, cancer, diseases of childbirth, infancy and childhood, respiratory diseases and tuberculosis. And research can do much toward teaching us how to keep well and how to prolong healthy human life.

Cancer is among the leading causes of death. It is responsible for over 160,000 recorded deaths a year and should receive special attention. Though we already have the National Cancer Institute of the Public Health Service, we need still more coordinated research on the cause, prevention and cure of this disease. We need more financial support for research and to establish special clinics and hospitals for diagnosis and treatment of the disease, especially in its early stages. We need to train more physicians for the highly specialized services so essential for effective control of cancer.

There is also special need for research on mental diseases and abnormalities. We have done pitifully little about mental illnesses.

Accurate statistics are lacking, but there is no doubt that there are at least two million persons in the United States who are mentally ill and that as many as ten million will probably need hospitalization for mental illness for some period in the course of their lifetime. A great many of these persons would be helped by proper care. Mental cases occupy more than one-half of the hospital beds at a cost of about 500 million dollars per year, practically all of it coming out of taxpayers' money. Each year there are 125,000 new mental cases admitted to institutions. We need more mental disease hospitals, more

outpatient clinics. We need more services for early diagnosis, and especially we need much more research to learn how to prevent mental breakdown. Also we must have many more trained and qualified doctors in this field.

It is clear that we have not done enough in peacetime for medical research and education in view of our enormous resources and our national interest in health progress. The money invested in research pays enormous dividends. If any one doubts this, let him think of penicillin, plasma, DDT powder and new rehabilitation techniques.

(K)—IV—The fourth problem has to do with the high cost of individual medical care. The principal reason why people do not receive the care they need is that they cannot afford to pay for it on an individual basis at the time they need it. This is true not only for needy persons. It is also true for a large proportion of normally self-supporting persons.

#### COST OF MEDICAL CARE

In the aggregate all health services—from public health agencies, physicians, hospitals, dentists, nurses and laboratories—absorb only about 4 per cent of the national income. We can afford to spend more for health. But 4 per cent is only an average. It is cold comfort in individual cases. Individual families pay their individual costs and not average costs. They may be hit by sickness that calls for many times the average cost—in extreme cases for more than their annual income. When this happens they may come face to face with economic disaster. Many families, fearful of expense, delay calling the doctor long beyond the time when medical care would do the most good.

For some persons with very low income or no income at all, we now use taxpayers' money in the form of free services, free clinics, and public hospitals. Tax-supported, free medical care for needy persons, however, is insufficient in most of our cities and in nearly all of our rural areas. This deficiency cannot be met by private charity or the kindness of individual physicians.

Each of us know doctors who work through endless days and nights, never expecting to be paid for their services because many of their patients are unable to pay. Often the physician spends not only his time and effort, but even part of the fees he has collected from patients able to pay, in order to buy medical supplies for those who cannot afford them.

I am sure there are thousands of such physicians throughout our country. They cannot, and should not, be expected to carry so heavy a load.

#### FIFTH PROBLEM

(L)—V—The fifth problem has to do with loss of earnings when sickness strikes. Sickness not only brings doctor bills; it also cuts off income.

On an average day there are about 7 million persons so disabled by sickness or injury that they cannot go about their usual tasks. Of these, about  $3\frac{1}{4}$  millions are persons who, if they were not disabled, would be working or seeking employment. More than one-half of these disabled workers have already been disabled for six months; many of them will continue to be disabled for years, and some for the remainder of their lives. Every year four or five hundred million working days are lost from productive employment because of illness and accident among those working or looking for work—about forty times the number of days lost because of strikes on the average during the ten years before the war. About nine-tenths of this enormous loss is due to illness and accident that is not directly connected with employment and is therefore not covered by workmen's compensation laws.

These, then, are the five important problems which must be solved if we hope to attain our objective of adequate medical care, good health and protection from the economic fears of sickness and disability.

(M)—To meet these problems, I recommend that the Congress adopt a comprehensive and modern health program for the Nation, consisting of five major parts—each of which contributes to all the others.

#### FIRST: CONSTRUCTION OF HOSPITALS AND RELATED FACILITIES

(N)—The Federal Government should provide financial and other assistance for the construction of needed hospitals, health centers and other medical, health, and rehabilitation facilities. With the help of Federal funds it should be possible to meet deficiencies in hospital and health facilities so that modern services—for both prevention and cure—can be accessible to all the people. Federal financial aid should be available not only to build new facilities where needed but also to enlarge or modernize those we now have.

(O)—In carrying out this program there should be a clear division of responsibilities between the states and the Federal Government. The states, localities and the Federal Government should share in the financial responsibilities. The Federal Government should not construct or operate these hospitals. It should, however, lay down minimum national standards for construction and operation and should make sure that Federal funds are allocated in those areas and projects where Federal aid is needed most. In approving state plans and individual projects, and in fixing the national standards, the Federal agency should have the help of a strictly advisory body that includes both public and professional members. Adequate emphasis should be given to facilities that are particularly useful for prevention of diseases—mental as well as physical—and to the coordination of various kinds of facilities. It should be possible to go a long way toward knitting together facilities for prevention with facilities for cure, the large hospitals of medical centers with the smaller institutions of surrounding areas, the facilities for the civilian population with the facilities for veterans. The general policy of Federal-state partnership which has done so much to provide the magnificent highways of the United States can be adapted to the construction of hospitals in the communities which need them.

#### SECOND: EXPANSION OF PUBLIC HEALTH, MATERNAL AND CHILD HEALTH SERVICES

Our programs for public health and related services should be enlarged and strengthened. The present Federal-state cooperative health programs deal with general public health work, tuberculosis and venereal disease control, maternal and child health services, and services for crippled children. These programs were especially developed in the ten years before the war and have been extended in some areas during the war. They have already made important contributions to national health, but they have not yet reached a large proportion of our rural areas, and in many cities they are only partially developed.

No area in the nation should continue to be without the services of a full time health officer and other essential personnel. No area should be without essential public health services or sanitation facilities. No area should be without community health services such as maternal and child health care.

Hospitals, clinics and health centers must be built to meet the needs of the total population and must make



adequate provision for the safe birth of every baby, and for the health protection of infants and children.

Present laws relating to general public health, and to maternal and child health, have built a solid foundation of federal coöperation with the states in administering community health services. The emergency maternity and infant care program for the wives and infants of servicemen—a great wartime service authorized by the Congress—has materially increased the experience of every state health agency and has provided much needed care. So too have other wartime programs such as venereal disease control, industrial hygiene, malaria control, tuberculosis control and other services offered in war essential communities. The Federal Government should coöperate by more generous grants to the states than are provided under present laws for public health services and for maternal and child health care. The program should continue to be partly financed by the states themselves and should be administered by the states. Federal grants should be in proportion to state and local expenditures and should also vary in accordance with the financial ability of the respective states.

The health of American children, like their education, should be recognized as a definite public responsibility. In the conquest of many diseases prevention is even more important than cure. A well rounded national health program should therefore include systematic and widespread health and physician education and examinations, beginning with the youngest children and extending into community organizations. Medical and dental examinations of school children are now inadequate. A preventive health program, to be successful, must discover defects as early as possible. We should therefore see to it that our health programs are pushed most vigorously with the youngest section of the population. Of course, federal aid for community health services—for general public health and for mothers and children—should complement and not duplicate prepaid medical services for individuals, proposed by the fourth recommendation of this message.

#### THIRD: MEDICAL EDUCATION AND RESEARCH

(P)—The Federal Government should undertake a broad program to strengthen professional education in medical and related fields, and to encourage and support medical research.

Professional education should be strengthened where necessary through Federal grants-in-aid to public and to nonprofit private institutions. Medical research, also, should be encouraged and supported in the Federal agencies and by grants-in-aid to public and nonprofit private agencies.

In my message to the Congress of Sept. 6, 1945 I made various recommendations for a general federal research program. Medical research, dealing with the broad fields of physical and mental illnesses, should be made effective in part through that general program and in part through specific provisions within the scope of a national health program. Federal aid to promote and support research in medicine, public health and allied fields is an essential part of a general research program to be administered by a central Federal research agency. Federal aid for medical research and education is also an essential part of any national health program if it is to meet its responsibilities for high grade medical services and for continuing progress. Coördination of the two programs is obviously necessary to assure efficient use of Federal funds. Legislation covering medical research in a national health program should provide for such coördination.

#### FOURTH: PREPAYMENT OF MEDICAL COSTS

(Q)—Everyone should have ready access to all necessary medical, hospital, and related services.

(R)—I recommend solving the basic problem by distributing the costs through expansion of our existing compulsory social insurance system. This is not socialized medicine.

Everyone who carries fire insurance knows how the law of averages is made to work so as to spread the risk and to benefit the insured who actually suffers the loss. If, instead of the costs of sickness being paid only by those who get sick, all people—sick and well—were required to pay premiums into an insurance fund, the pool of funds thus created would enable all who do fall sick to be adequately served without overburdening any one. That is the principle on which all forms of insurance are based.

During the past fifteen years, hospital insurance plans have taught many Americans this magic of averages. Voluntary health insurance plans have been expanding during recent years; but their rate of growth does not justify the belief that they will meet more than a fraction of our people's needs. Only about 3 per cent or 4 per cent of our population now have insurance providing comprehensive medical care. A system of required prepayment would not only spread the costs of medical care, it would also prevent much serious disease. Since medical bills would be paid by the insurance fund, doctors would more often be consulted when the first signs of disease occur instead of when the disease has become serious. Modern hospital, specialist and laboratory services, as needed, would also become available to all and would improve the quality and adequacy of care. Prepayment of medical care would go a long way toward furnishing insurance against disease itself as well as against medical bills.

(S)—Such a system of prepayment should cover medical, hospital, nursing and laboratory services. It should also cover dental care as fully and for as many of the population as the available professional personnel and the financial resources of the system permit.

The ability of our people to pay for adequate medical care will be increased if, while they are well, they pay regularly into a common health fund instead of paying sporadically and unevenly when they are sick.

This health fund should be built up nationally in order to establish the broadest and most stable basis for spreading the costs of illness and to assure adequate financial support for doctors and hospitals everywhere. If we were to rely on state by state action only, many years would elapse before we had any general coverage. Meanwhile health service would continue to be grossly uneven, and disease would continue to cross state boundary lines.

Medical services are personal. Therefore the nationwide system must be highly decentralized in administration. The local administrative unit must be the keystone of the system so as to provide for local services and adaptation to local needs and conditions. Locally as well as nationally, policy and administration should be guided by advisory committees in which the public and the medical profession are represented.

(T)—Subject to national standards, methods and rates of paying doctors and hospitals should be adjusted locally. All such rates for doctors should be adequate, and should be appropriately adjusted upward for those who are qualified specialists.

(U)—People should remain free to choose their own physicians and hospitals. The removal of financial barriers between patient and doctor would enlarge the present freedom of choice. The legal requirement on the population to contribute involves no compulsion over the doctor's freedom to decide what services his patient needs.

(V)—People will remain free to obtain any medical service outside of the health insurance system if they

desire, even though they are members of the system; just as they are free to send their children to private instead of to public schools, although they must pay taxes for public schools.

(W)—Likewise physicians should remain free to accept or reject patients. They must be allowed to decide for themselves whether they wish to participate in the health insurance system full time, part time, or not at all.

A physician may have some patients who are in the system and some who are not. Physicians must be permitted to be represented through organizations of their own choosing, and to decide whether to carry on in individual practice or to join with other doctors in group practice in hospitals or in clinics.

(X)—Our voluntary hospitals and our city, county and state general hospitals, in the same way, must be free to participate in the system of whatever extent they wish. In any case they must continue to retain their administrative independence.

#### VOLUNTARY ORGANIZATIONS

Voluntary organizations which provide health services that meet reasonable standards of quality should be entitled to furnish services under the insurance system and to be reimbursed for them. Voluntary coöperative organizations concerned with paying doctors, hospitals or others for health services, but not providing services directly, should be entitled to participate if they can contribute to the efficiency and economy of the system.

None of this is really new. The American people are the most insurance minded people in the world. They will not be frightened off from health insurance because some people have misnamed it "socialized medicine."

(Y)—I repeat—what I am recommending is not socialized medicine.

Socialized medicine means that all doctors work as employees of government. The American people want no such system. No such system is here proposed. Under the plan I suggest, our people would continue to get medical and hospital services just as they do now—on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all important difference: Whether or not patients get the services they need would not depend on how much they can afford to pay at the time.

(Z)—I am in favor of the broadest possible coverage for this insurance system. I believe that all persons who work for a living and their dependents should be covered under such an insurance plan. This would include wage and salary earners, those in business for themselves, professional persons, farmers, agricultural labor, domestic employees, government employees and employees of non-profit institutions and their families.

(Aa)—In addition, needy persons and other groups should be covered through appropriate premiums paid for them by public agencies. Increased Federal funds should also be made available by the Congress under the public assistance programs to reimburse the states for part of such premiums, as well as for direct expenditures made by the states in paying for medical services provided by doctors, hospitals and other agencies to needy persons.

(Bb)—Premiums for present social insurance benefits are calculated on the first \$3,000 of earnings in a year. It might be well to have all such premiums, including those for health, calculated on a somewhat higher amount, such as \$3,600.

A broad program of prepayment for medical care would need total amounts approximately equal to 4 per cent of such earnings. The people of the United States have been spending, on the average, nearly this percentage of their incomes for sickness care. How much of the

total fund should come from the insurance premiums and how much from general revenues is a matter for the Congress to decide. The plan which I have suggested would be sufficient to pay most doctors more than the best they have received in peacetime years. The payments of the doctors' bills would be guaranteed, and the doctors would be spared the annoyance and uncertainty of collecting fees from individual patients. The same assurance would apply to hospitals, dentists and nurses for the services they render. Federal aid in the construction of hospitals will be futile unless there is current purchasing power so that people can use these hospitals. Doctors cannot be drawn to sections which need them without some assurance that they can make a living. Only a nationwide spreading of sickness costs can supply such sections with sure and sufficient purchasing power to maintain enough physicians and hospitals. We are a rich nation and can afford many things. But ill health which can be prevented or cured is one thing we cannot afford.

#### COMPREHENSIVE HEALTH PROGRAM

(Cc)—Fifth—Protection against loss of wages from sickness and disability. What I have discussed heretofore has been a program for improving and spreading the health services and facilities of the nation and providing an efficient and less burdensome system of paying for them. But no matter what we do, sickness will of course come to many. Sickness brings with it loss of wages. Therefore, as a fifth element of a comprehensive health program, the workers of the nation and their families should be protected against loss of earnings because of illness. A comprehensive health program must include the payment of benefits to replace at least part of the earnings that are lost during the period of sickness and long term disability. This protection can be readily and conveniently provided through expansion of our present social insurance system, with appropriate adjustment of premiums.

Insurance against loss of wages from sickness and disability deals with cash benefits, rather than with services. It has to be coordinated with the other cash benefits under existing social insurance systems. Such coördination should be effected when other social security measures are re-examined. I shall bring this subject again to the attention of the Congress in a separate message on social security.

I strongly urge that the Congress give careful consideration to this program of health legislation now.

Many millions of our veterans, accustomed in the armed forces to the best of medical and hospital care, will no longer be eligible for such care as a matter of right except for their service connected disabilities. They deserve continued adequate and comprehensive health service. And their dependents deserve it too.

By preventing illness, by assuring access to needed community and personal health services, by promoting medical research and by protecting our people against the loss caused by sickness we shall strengthen our national health, our national defense and our economic productivity. We shall increase the professional and economic opportunities of our physicians, dentists and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people.

We need to do this especially at this time because of the return to civilian life of many doctors, dentists and nurses, particularly young men and women.

Appreciation of modern achievements in medicine and public health has created widespread demand that they be fully applied and universally available. By meeting that demand we shall strengthen the nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land.



## EARLY PUBLIC HEALTH IN CALIFORNIA\*

N. K. FOSTER, M.D., STATE HEALTH OFFICER, 1904-1910  
BUBONIC PLAGUE OUTBREAK, 1900-1905

GUY P. JONES  
*San Francisco*

WHEN Dr. N. K. Foster of Oakland became Secretary of the California State Board of Health in 1903 he found the State health organization at its ebb. Dr. George C. Pardee of Oakland, upon his election as Governor, had appointed Dr. Foster as secretary of the board.

Doctor Newel Kelly Foster was born in Centerbury, New Hampshire, on April 10, 1849. In college he graduated from the newly established Cornell University in 1873. Other collegiate work was taken at the University of Michigan, after which he entered Long Island College Hospital, receiving his M.D. degree as a member of the class of 1878. For several years he practiced medicine in Varna, New York, and in Laramie, Wyoming, then moving to Oakland where he practiced through the years 1886 to 1904. In 1904 he became Secretary of the California State Board of Health, acting in that capacity through 1910. From 1910 to 1920 he was Director of Health Development and Sanitation in the Oakland Public Schools. His death took place on September 9, 1926.

The members of the California State Board of Health during the period 1904 to 1910, at which time Doctor N. K. Foster was Secretary, consisted of the following: Martin Regensburger, San Francisco, President; N. K. Foster, Sacramento, Secretary; F. K. Ainsworth, San Francisco; W. A. Briggs, Sacramento; A. C. Hart, Sacramento; O. Stansbury, Chico; W. Le Moyne Wills, Los Angeles.

## CALIFORNIA BUBONIC PLAGUE OUTBREAK OF 1900-1904

In addressing the health officers of California at their annual meeting held at Stanford University in 1922, Dr. Foster gave the following interesting account of his experiences upon entering the State office:

"If I were limited to one word in stating the necessity of a State health organization, I should without hesitation say, *Plague*, for in many ways the breaking out of that disease focused attention on our lax health organization and made imperative a radical improvement, or have California cut off by quarantine from communication with other States.

"Plague was first recognized in San Francisco in March, 1900, and of course caused a great deal of comment. Many strongly believed that it did not and could not exist. The State Board of Health, however, admitted its existence. Many leading newspapers and public men thought otherwise—and believed that even if it did exist any publicity would hurt the State. They strenuously denied its existence and the State Board of Health was induced, or did reverse itself and also declared the disease was not plague. This aroused the ire of eastern health officers and exaggerated stories were published there of its ravages—people were dropping dead on the streets, it was said. They were so wrought up that the health authorities of 21 States requested Surgeon-General Walter Wyman to call a conference of the State Board of Health with the U. S. Public Health and Marine Hospital Service for the purpose of dealing with the situation. The conference was called and met in January, 1903. California was represented by Dr. Mathew

Gardner—a member of our State Board of Health. He was given a very unhappy half hour by the thoroughly angered and possibly frightened health officers—and a quarantine resolution against California was introduced. Through the influence of General Wyman it was left as unfinished business for a conference to be called later.

"Meanwhile things were doing in California. During the years 1900, 1901, 1902, 1903, there had been 110 cases of plague authenticated with 105 deaths and some people were beginning to be alarmed.

"At the general election Dr. Geo. C. Pardee was elected Governor and at once interested himself in the situation. The California State Board of Health is organized by the Governor nominating the members and the Senate ratifying the nominations. Governor Gage had nominated the board that denied the existence of plague but the Senate had neglected to ratify—so they were acting only at the pleasure of the Governor. Governor Pardee, feeling deeply the gravity of the situation, with a quarantine hanging over us—withdrew the nomination and appointed a new board with the exception of Dr. Mathew Gardner. He, however, died in two weeks and we were deprived of his splendid ability. This was in February or March, 1903. On April 1st the new board met with the old and after the old had closed up their business—the new one organized and I had the honor to be elected Secretary and Executive Officer.

STATE DEPARTMENT OF PUBLIC HEALTH EQUIPMENT  
IN 1903

"After adjournment, I called on my predecessor, who had his desk in the office of the State Lunacy Commission, and asked for the property of the board. With a quizzical look he said, 'Property of the board, it has no property. That desk is mine and every scrap of paper in it.' He did, however, give me a bunch of letter heads and pointing to the bay window said, 'Those old reports of other State boards are at your disposal.' He sat between his desk and the steel safe, made famous by the sarcastic remarks of Carrie Nation as she 'hatchetted' her way through the State, and said, 'Sit down and I'll give you some advice.' I was receptive, thinking to get some pointers on the work. Instead, 'You have a good practice, stay with it, have some one open your mail and attend to it, come once a month and draw your pay and show yourself, and let me show you how to make out your expense account for the trip. He proceeded to put down items, some of which I had, some not, dinner \$5 and everything in proportion. I said, 'But Doctor, it didn't cost that much.' 'Oh! that doesn't matter, you have \$1,500 a year to spend on the expenses of the board and you have to get rid of it. You might as well have it as anybody.'

"Not a bright outlook and I went to my room in none too happy a mood. No desk—no chair and no place to put them if I had.

"Next morning, I interviewed Mr. Mellick, Secretary of the State Board of Examiners. He had large offices, but personally he was using, during the interim of the legislative session, the Lieutenant Governor's room. He kindly let me have desk room there also. The janitor rustled me a desk and chair and I turned to the pile of old State reports. With them, I found many unopened letters and this gave me a start to work. Some were months old and some had in them stamps to insure a reply. I didn't blame one doctor, who was acting as best he could as health officer in his village, for using some pretty powerful language. He said, 'This is the third time I have written and have no reply and by —— it is the last.' I replied that a new deal was ordered and that in future he would get some sort of a reply by return mail.

"Do you blame me for feeling lonely and blue? I had

\*From the California State Department of Public Health.

Guy P. Jones, author of the above article, for many years edited the Bulletin of the California State Board of Public Health. During the last year, he has retired from State work and is now living in Guadalajara, Mexico.

given up my practice and broken up my home believing I was to fill, or try to fill, an office of honor—and I found nothing but disgrace abroad and contempt at home—and right there the seed of this association was planted.

"The need of work and organized work was forced on me in those hours of discouragement. I saw the futility of my working without the aid and coöperation of others throughout the State. An account of the June 3rd Plague conference in Washington where we fought it out and instead of a quarantine got a resolution of confidence has no place here.

#### STATE HEALTH DIRECTOR FOSTER'S EARLY TASKS

"It was a busy spring and summer I spent trying to arouse interest in public health matters. I attended all the medical societies I could, visited the different health officers and answered all calls for help in person. I met with willingness everywhere but a good deal of incredulity that the State Board of Health was anything but a political sinecure and it seemed to me they all came from Missouri and had to be shown. Very well, I determined to show them.

"From the nature of things, the executive officer of the board at that time had most of the work to do, there were no assistants, not even a stenographer, but never was such officer backed up by a better board. Throughout the six years we were together, there was never a jar in the organization and they always stood behind me. The Governor also was always ready to help to the limit. Things began to move but the need of organization was always making itself felt. There were no laws and it was everyone for himself." . . .

#### REHABILITATION OF CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH

To Dr. Foster must be given full credit for the organization of the California State Department of Public Health along modern standard lines. It was he who secured legislation in 1905 and 1907 to provide for the organization of the Bureau of Vital Statistics, Bureau of Pure Foods and Drugs, and the State Hygienic Laboratory. Actually during the period that Dr. Foster served, from 1903 to 1909, he secured the passage of fundamental legislation that has established the pattern upon which the present State public health organization is built. At the same time he conducted, by himself, a State-wide epidemiological service.

Although not in vigorous health, he answered emergency calls from one end of the State to another, giving advice on the control of and assisting in the diagnosis of typhoid fever, smallpox, plague, diphtheria, and many other communicable diseases. In those days typhoid fever was a common disease and smallpox was rampant throughout the State.

He accomplished more in the six years that he served as health officer than any of his immediate predecessors. He had a thorough and deep knowledge of public health and put up a continuous fight for legislative action that would provide efficient facilities for the promotion and maintenance of public health in California. The bureaus that he established during his tenure of office have been functioning continuously since that time and have established their essential offices in the maintenance of public health. Others, of course, were established at various intervals.

It has been stated that Dr. Thomas M. Logan, the first secretary of the California State Board of Health, was the George Washington of public health in California, and that Dr. N. K. Foster was the Abraham Lincoln of public health in this State. There is considerable realism in this allusion for when Doctor Foster assumed office there was virtually no State public health organization in California. It was only through his knowledge, energy,

enthusiasm, and ability to secure proper legislation that the California State Board of Health was established definitely as a distinct unit in the State government.

The development of the organization since that time is a matter of record. To Dr. Foster, public health workers of California owe a deep debt of gratitude, for without his foresight it is doubtful that public health in California would be established upon the high plane that prevails at this time.

Through Dr. Harry E. Foster of the Cutter Laboratories in Berkeley, his father's diary has been made available to the writer. The daily record of disappointment, heartbreaking work, overcoming of difficulties, and remarkable accomplishments makes thrilling reading. That one man could successfully carry on the whole State public health work by himself over a period of years and then leave an organization of dependable units to establish and carry on modern standard public health service is a remarkable accomplishment for shortly after the turn of the century.

668 Phelan Building, 760 Market Street.

#### \$375 Million Health Bill Up

Washington, Oct. 24.—Congress was asked today to put up \$375 million dollars toward construction of hospitals and health centers during the next five years.

Nearly 50 per cent of the money would go to Southern states.

The Senate education and labor committee, in line with President Truman's request for legislation authorizing Federal aid toward hospital construction, has approved a measure which would:

1. Provide for Federal grants of 75 million dollars a year for five years beginning with fiscal 1947. The Government's contribution would range from 33 1/3 per cent in the richest states to 75 per cent in the poorest.

3. Authorize immediate expenditure of five million dollars to pay half the cost of surveys of hospitals and health centers needed in each state.

3. Create a special Federal hospital council through which state building plans would be cleared.

Senator Lister Hill (D., Ala.), sponsor of the measure, said he expects to call it up for Senate action next week. —San Francisco News, October 24.

#### Explore the Details First

Probably one of the reasons why Congress has been slow to include compulsory health insurance legislation such as proposed in the Wagner-Dingell Bill as part of the Federal social security program, is the problem of cost in proportion to benefits. The Wagner-Dingell Bill specifically provides that social security payroll taxes be raised to a total of eight per cent, half to be paid by the employer and half by the employee. Of the eight per cent, four per cent is intended to defray the expense of medical care, hospitalization, and temporary disability. Thus the wages of a person earning \$225 per month would be subject to a total social security tax of \$216 annually, half of which would be deducted directly from the salary check. One-hundred-and-eight dollars of the \$216 would be for medical and temporary disability protection.

How does this compare with the cost of accident, health and hospitalization insurance in government-regulated insurance companies in group form?

Here is what can be purchased for \$39 per year: \$30 weekly benefits for illness and accident, \$5 daily hospital benefit for a 70-day period, plus \$25 for laboratory medicines, x-ray and other charges, plus up to \$150 reimbursement for surgical expenses. Hospital benefits are paid for 70 days just as many times in a year as the employee may need them. Also, when a contract is purchased from a private company, it cannot be changed by the insurance company as long as payments are made. Any government insurance plan may be changed at the will of Congress. These are but a few of the details that should be explored before the country goes overboard for state medicine. —Bloomington News, October 12.

America is God's Crucible, the great Melting-Pot where all the races of Europe are melting and re-forming! . . . God is making the American.

—Israel Zangwill, *The Melting-Pot*, Act i. Produced in New York City, Oct., 1908.



# CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

## CALIFORNIA MEDICAL ASSOCIATION†

PHILIP K. GILMAN, M.D.....President  
SAM J. McCLENDON, M.D.....President-Elect  
E. VINCENT ASKEY, M.D.....Speaker  
LEWIS A. ALESEN, M.D.....Vice-Speaker  
PHILIP K. GILMAN, M.D.....Council Chairman  
JOHN W. CLINE, M.D...Chairman, Executive Committee  
GEORGE H. KRESS, M.D..Secretary-Treasurer and Editor  
JOHN HUNTON .....Executive Secretary

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Albert J. Scholl, Los Angeles

#### *Executive Committee:*

Lambert B. Coblenz, San Francisco  
H. J. Templeton, Oakland  
Albert J. Scholl, Los Angeles  
George W. Walker, Fresno

#### *Anesthesiology:*

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#### *Radiology:*

R. R. Newell, San Francisco  
John W. Crossan, Los Angeles

#### *Urology:*

Frank Hinman, San Francisco  
Albert J. Scholl, Los Angeles

#### *Pharmacology:*

W. C. Cutting, Menlo Park  
Clinton H. Thienes, Los Angeles

† For complete roster of officers, see advertising pages 2, 4, and 6.

## OFFICIAL NOTICES

### COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

#### Minutes of the Three Hundred Twenty-ninth (329th) Meeting of the Council of the California Medical Association

The meeting was called to order at 10:00 A.M., on Sunday, October 21, 1945, at the Hotel Biltmore, Los Angeles.

#### 1. Roll Call:

Councilors Present: Philip K. Gilman, Chairman; E. Vincent Askey, Edwin L. Bruck, E. Earl Moody, Edward B. Dewey, Walter S. Cherry, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, and George H. Kress, Secretary.

Councilors Absent: Sam J. McCleendon, Sidney J. Shipman, Dewey R. Powell (ill), R. Stanley Kneeshaw, and John W. Green.

Present by Invitation: C.M.A. Delegates to the A.M.A. Dwight L. Wilbur, Lowell S. Goin, Dwight H. Murray, H. Gordon MacLean, and Donald Cass; Alternate Delegate to the A.M.A. Leo J. Madsen; L. A. Alesen, Vice-Speaker; Harold A. Fletcher, Chairman of the C.M.A. Postwar Planning Committee; W. M. Bowman, for C.P.S.; Howard Hassard, Associate Legal Counsel; Ben H. Reed, Secretary, California Public Health League; W. Glenn Ebersole; E. T. Remmen, Chairman Local Committee on Arrangements for 1946 C.M.A. Annual Session; Stanley K. Cochems, Executive Secretary, Los Angeles County Medical Association; Fred W. Borden, Secretary, Santa Clara County Medical Society, and Chester L. Cooley, C.P.S. Secretary.

#### 2. Minutes:

Minutes of the following meetings of the Council and Executive Committee were submitted and actions taken approved:

(a) Council Meeting (328th) held in San Francisco on August 12, 1945. (Printed in CALIFORNIA AND WESTERN MEDICINE, October, 1945, page 175.)

(b) Executive Committee Meeting (195th) held in San Francisco, September 26, 1945. (Printed in CALIFORNIA AND WESTERN MEDICINE, October, 1945, page 181.)

(c) Special Meeting of the "Members of 'Trustees of the California Medical Association'", (18th), held in San Francisco, on August 12, 1945.

#### 3. Membership:

(a) A report of the membership as of October 15, 1945, was submitted and placed on file. The membership roster showed distribution as follows:

Total members (civilian and military) listed for year 1945: 7,839.

Total members in military service: 2,229.

(b) On motion made and seconded, it was voted to reinstate 7 members whose 1945 dues had been paid subsequent to April 1, 1945.

(c) On motion made and seconded, Retired Member-

\* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

ship was granted to the following members, whose applications had been received in accredited form from their county societies:

Paul Campiche, San Francisco County  
William Humes Roberts, Los Angeles County  
W. Frank Holman, Los Angeles County  
Donald J. Frick, Los Angeles County

(d) Association Secretary Kress referred to correspondence with A.M.A. Secretary West on whether Retired Members of the California Medical Association are eligible for A.M.A. Fellowship. Secretary West had written that the matter had been referred to the A.M.A. Judicial Council, but no opinion had been rendered by the A.M.A.

#### 4. Financial:

(a) A cash report as of October 15, 1945, was submitted.

(b) Report was made concerning income and expenditures for September and Nine Months ending September 30, 1945.

(c) A balance sheet, as of September 30, 1945, was submitted.

On motion made and seconded, the above reports were received and placed on file.

#### 5. Interim Appointments:

Council Chairman Gilman informed the Council that he had appointed the Local Committee on Arrangements for the 1946 Annual Session of the California Medical Association, as follows: E. T. Remmen, Los Angeles, Chairman; L. A. Alesen, Los Angeles; Louis J. Regan, Los Angeles; W. H. Geistweit, Jr., San Diego; Arthur E. Varden, San Bernardino; George H. Kress, San Francisco (ex-officio, through by-law provision); and Stanley Cochems, Los Angeles. The appointments were approved.

#### 6. Special Committee on Prepayment Plans and C.P.S.:

Doctor Gilman made a progress report concerning the meetings of the Special Committee on Prepayment Plans and California Physicians' Service, of which committee Loren R. Chandler is chairman.

#### 7. C.M.A. Advisory Planning Committee:

Mr. Hassard, reporting for the Advisory Planning Committee, presented the recommendations made at the third meeting of that committee, held on September 24th, as follows:

The chairman reported that at the last meeting of the Council there was referred to this committee for study and recommendation, a written proposal dated July 5, 1945, addressed to the California Medical Association by several of the insurance companies in California (the companies being Occidental Life Insurance Company, Pacific Employers Insurance Company, California-Western States Life Insurance Company, Federal Life Insurance Company, and the Associated Indemnity Company). The written proposal was then considered in detail. In substance, it requests the California Medical Association to approve a fee schedule to be included in all medical and surgical indemnity contracts, and to use its best efforts to require physicians to limit their charges to policy holders to the amount of the fee schedule, except where policy holder's income is over \$4,000 per year. The proposal also suggested that all contracts issued with the California Medical Association's approved fee schedule be publicized under the name "California Plan."

After full discussion, it was unanimously decided to recommend to the Council as follows:

1. That the insurance companies be notified that the California Medical Association regrets that it is not feasible or practical for the California Medical Association

to adopt or recommend to its members any schedule of fees for general application in the practice of medicine and surgery. (Council approved.)

2. That the California Medical Association inform the insurance companies that the medical profession is at all times alert to the matter of gross overcharging of patients, and that whenever evidence of gross overcharging is presented to the organized profession, it is most anxious to take all steps within its power to remedy such inequity as may exist; and that for such purpose the larger county medical societies have permanent Grievance Committees which, on proper complaint brought by a patient, can and will investigate claimed overcharges, and, if warranted, can and will institute disciplinary proceedings. Bearing in mind that a charge that is unwarranted in relation to the services rendered by any physician is a collective responsibility of the medical profession, it was further recommended that the Council officially call to the attention of all component county societies the fact that California insurance companies issuing medical or surgical indemnity policies have complained that a small percentage of doctors habitually overcharge, and urging each county medical society either to establish a Grievance Committee, if none now exists, or to request its existing Grievance Committee to use every effort to locate any instances of gross overcharging that may exist in the county, and take all steps possible to prevent repetition of overcharging. (Council approved.)

3. That the Council adopt a symbol or mark (e.g., a golden bear and the words "California Plan for Health Security") to be used by all bona fide reputable organizations in the voluntary health insurance field, and to be publicized throughout the State as a symbol of merit, with the purpose of thereby stimulating public interest in voluntary health insurance, and that the insurance companies be requested to join with the California Medical Association and California Physicians' Service and Blue Cross plans in promoting such a symbol or mark. (Council to pass on symbol to be adopted. Symbol to be owned by C.M.A. and copyrighted. Its use be permitted only by those insurance plans that meet the "Principles on Health Insurance" adopted by the Council at its August meeting.) (Council approved.)

4. That the Council propose to the insurance companies that a comprehensive plan be entered into under which California Physicians' Service and the Blue Cross organizations would cover medical, surgical and hospital services and care, the insurance companies would cover group life insurance and cash indemnity for loss of time during illness or injury, and under which the entire package would be sold to the public through the existing sales outlets of the insurance companies, such a plan to involve no sales commissions payable by California Physicians' Service or Blue Cross, except possibly a minimum commission to reimburse the insurance companies for their actual out-of-pocket costs. It was recommended that this plan be proposed, together with a publicity campaign founded upon an approved symbol, as a joint undertaking without any element of profit to anyone, in order that the maximum voluntary health insurance coverage can be obtained and the threat of compulsory health insurance thwarted. (Council approved.)

Mr. Reed then reported on the first public hearing conducted by the Assembly Interim Committee on Health Care at Los Angeles Friday, September 7, 1945: Doctor Askey and Mr. Cochems had appeared on behalf of the California Medical Association, and Mr. Von T. Ellsworth appeared for the Farm Bureau. Mr. Ellsworth complained bitterly about the supposed California Medical Association opposition to group practice. Assemblyman Collins suggested that the California Medical Association adopt a resolution clarifying its attitude on group



practice. The committee then decided to recommend that a letter be written to Assemblyman Collins pointing out that the California Medical Association's principles on health insurance covered the entire subject.

After discussion, it was unanimously decided to recommend that each of the District Councilors on the California Medical Association's Council invite all component society secretaries in their districts to attend meetings of the Council, as observers, (C.M.A. not to be responsible for travel expenses.) In this connection, Doctor Remmen pointed out that it was difficult for the county society secretaries to keep abreast of all events through correspondence, and that attendance at Council meetings would prove both informative and stimulating. (Council approved.)

The Advisory Planning Committee unanimously recommended that Mr. Frank J. Kihm, Executive Secretary of the San Francisco County Medical Society, be appointed by the Council a member of the committee. (Council approved.)

The recommendations made at the fourth meeting of the Advisory Planning Committee held on October 17th, as per report made by Mr. Ben Read, were approved as follows:

Mr. Read gave a progress report covering the Washington office maintained by the United Public Health League. The present situation with respect to the Wagner-Murray-Dingell Bill, the hospital construction bill, Veterans Administration legislation and other national matters were reported and discussed. It was decided to recommend to the Council that the medical profession in this State, through appropriate organizations, obtain in advance the views of every candidate for a State or National office at the next California general election in 1946, with respect to the subject of medical costs and their distribution and that those candidates whose publicly expressed views are in the public interest be wholeheartedly supported and those candidates whose views do not accord with the public interest be vigorously opposed.

#### 8. California Physicians' Service:

Reports were made by C.P.S. Secretary Chester L. Cooley, and C.P.S. Director W. M. Bowman.

Doctor Cooley referred to the meeting of C.P.S. Trustees held on October 20th, and among items receiving comment were the following: Court suit now pending concerning certain legal phases; better understanding with commercial insurance carriers; status of the medical service rendered in housing areas, and that all housing medical service units except that in Vallejo had been closed; new fee schedules for C.P.S. professional members; Alameda County and Sacramento County problems, in relation to services rendered by professional members.

Discussion was participated in by Councilors Kindall, MacDonald and Cline, and on motion made and seconded, it was voted that the Council request the Sacramento Society for Medical Improvement to make possible a conference at a regular or special meeting, at which C.P.S. problems of mutual interest could be discussed.

Mr. Bowman, Director of C.P.S., referred to the following items: Prospective new groups who might come into C.P.S.; activities of the four speakers to service clubs whose salaries were paid through allocation from the C.M.A.; financial status of C.P.S., stating that in September, C.P.S. received \$26,000 in excess of expenditures.

Other comment was made by Doctor Lowell S. Goin, President of the C.P.S. Trustees. Doctor Goin gave a break-down of payments received in his office from 100 C.P.S. chest patients as contrasted to payments received from 100 private chest patients; the income from the C.P.S. group was \$3,762.00; and from the same number of private patients, \$3,848.50.

Suggestion was made that it would be interesting if similar break-downs could be obtained from, say ten surgeons representing rural and urban areas, and ten specialists; the thought being expressed that such an analysis would demonstrate that the money actually received from C.P.S. patients is quite in line with the income that would be received from the same number of private patients.

Reference was also made to a letter of September 10th, received from Doctor James N. Neil of Oakland, concerning C.P.S. It was voted to send this letter to the Committee on Prepayment Plans and C.P.S., of which Doctor Chandler is chairman.

#### 9. Report of C.M.A. Committee on Postwar Plans for the Medical Profession:

Doctor Harold A. Fletcher, Chairman of the C.M.A. Committee on Postwar Planning, and also Chairman of the California Procurement and Assignment Service for Physicians, submitted a report in which the conditions that had developed in California incident to the return of a large number of military colleagues from both California and other states, were taken up in detail.

The report dealt with the procedures designed to protect the rights of California colleagues who are still in military service, the plans in regard thereto to apply both to California and other state physicians who desire to reestablish themselves in practice. Concerning California colleagues, it was felt that until conditions are more settled, all such colleagues should go back to their former places of practice, rather than reestablish themselves in some other California community.

It was stated there is no legal power to prevent a man from establishing himself wherever he desires. However, the State and County Procurement and Assignment Services for Physicians were agreed that they would not construe a returning physician "essential for civilian practice" in any particular community, if physicians who formerly practiced in that community were still in military service, and the community was not in need of additional physicians. Every case is to be treated as an individual proposition, and in accordance with the needs of the community.

(The full report by State Procurement and Assignment Service Chairman Fletcher appears in CALIFORNIA AND WESTERN MEDICINE for November, on page 228. Editorial comment in regard thereto appears in the same issue on page 205. A letter outlining the procedure adopted by the Santa Clara County Procurement and Assignment Service, submitted by Doctor Fred W. Borden, Chairman, appears on page 229 of the November issue of CALIFORNIA AND WESTERN MEDICINE.)

After full discussion, the Council voted to approve the recommendations made by the P. & A. Service, and that steps be taken to acquaint the component county medical societies and the A.M.A. with the recommendations made therein.

Doctor Fletcher suggested that Editor Kress also make editorial mention in regard to the report.

#### 10. A.M.A. in San Francisco in 1946:

Association Secretary Kress stated a telegram had been received from A.M.A. Secretary West, stating that if transportation and meeting facilities are available in San Francisco in 1946, the Annual Session of the American Medical Association previously scheduled for San Francisco in that year, if held, might not take place until July or August, 1946.

Mention was made of the activities of the San Francisco Convention Bureau, whose Director, Mr. Walter G. Swanson, in conjunction with C.M.A. Officers, is carrying on the negotiations for meeting facilities in the Civic Center.

It was stated that decision concerning the date of the 1946 A.M.A. meeting might be made by the Trustees and

the House of Delegates of the A.M.A. at the meeting to be held in Chicago on December 3-6, 1945.

#### 11. Annual Dues for 1946:

(a) The Council discussed the dues of members returning from military service, with special reference to period of time a waiver of dues should continue after military colleagues had returned to civilian status.

After consideration by a sub-committee, consisting of Doctors Cline, MacDonald, and Askey, the following resolution was presented and approved by the Council:

WHEREAS, Returning military members of the California Medical Association have been and are under disruption of their economic status by factors beyond their control; and

WHEREAS, Payment of dues during the period of time of recent discharge from the service might work a hardship on them; therefore be it

*Resolved*, That military leave (for service in the Armed Forces) be considered as in force until January 1, 1947, for all those who have been granted such military leave of absence; and be it further

*Resolved*, That the Council of the California Medical Association recommend to the House of Delegates at the next session to consider what is its wish in regard to those members who are still in service after January 1, 1947.

(This would eliminate payment of the \$100.00 dues by any military member and would postpone until January 1, 1947 (1½ years) the payment of any dues except as specifically ordered by the House of Delegates after considering all angles of the problem.)

(b) Doctor Gilman called attention to letters that had been received concerning the 1946 dues that were adopted by the C.M.A. House of Delegates in May, 1945. Attention was called to the fact that the Council has no authority in the matter, since the action had been taken by the supreme body of the Association; namely, the C.M.A. House of Delegates.

#### 12. Annual Session of California Medical Association in 1946:

Chairman of the Committee on Scientific Work, Doctor Kress, placed before the Council some queries concerning next year's Annual Session, regarding dates, number of days of meeting, and place of meeting.

The 1945 House of Delegates having voted that the 1946 Annual Session should be held in Los Angeles, the Council heard reports concerning hotel facilities and agreed that the Hotel Biltmore would be the preferable place of meeting, particularly since it would be possible also to make arrangements for commercial exhibits.

Also, since there had been no regular meeting during the war period, it was felt that a regular four-day session would be desirable; and that the meeting should begin on Tuesday, May 7, 1946, and be carried on through Friday noon, May 10, 1946. It was so voted.

#### 13. "California and Western Medicine":

(a) Attention was called to trade printing conditions which have much to do with the somewhat delayed and irregular appearance of CALIFORNIA AND WESTERN MEDICINE. The printers are making efforts to overcome their manpower difficulties as rapidly as possible.

(b) Attention was also called to a letter received from the Trustees of the American Medical Association, dated October 3, 1945, in which the A.M.A. Trustees served notice that the A.M.A. Coöperative Medical Advertising Bureau might be discontinued at the end of the current year. It was stated that this subject had been given over to the Executive Secretary for further consideration.

#### 14. Association of California Hospitals:

Doctors Gilman and Cline made comment concerning

the plan submitted to the Executive Committee of the C.M.A., by George U. Wood, Chairman of the Blue Cross Committee of the Association of California Hospitals.

Executive Committee Chairman Cline outlined to the Council the discussions that had taken place relative to the plan submitted by Doctor Wood, having the title, "The American Plan."

Mention was made of the modifications which the C.M.A. Executive Committee felt should be made in regard thereto. Doctor Cline referred to the several committees that had been appointed by the C.M.A. Council at the instance of the Association of California Hospitals and the three Blue Cross organizations, stating that out of the discussions and presumable agreements, nothing had as yet developed, beyond the proposed action submitted by Dr. Wood.

Doctor Cline referred to a letter that had been sent by the C.M.A. Executive Committee in reply to Doctor Wood. This letter emphasized the necessity of having a uniform statewide plan in Blue Cross activities and that it was important to have direct corporate authority vested in the conference groups.

Upon motion made and seconded, it was voted that the California Medical Association appoint a conference committee consisting of five members, the committee however, to have no power for commitments. The committee consists of: Doctors Sam J. McClendon, San Diego; E. Vincent Askey, Los Angeles; Chester L. Cooley, San Francisco; John W. Cline, San Francisco; and Ernest W. Page, Berkeley.

Concerning the plan submitted by Doctor Wood, other discussion followed. Incorporated in Doctor Wood's statement were the following:

The Board of Trustees of the Association of California Hospitals approved the recommendation of the Blue Cross Committee, recommending to the California Medical Association that we pool our efforts in the development of a uniform plan for the State of California.

The plan proposes the following features:

1. It should be sponsored by the California Medical Association and the Association of California Hospitals and other allied professions.

2. It should be voluntary rather than compulsory.

3. It should assure the individual free choice of doctor, dentist and hospital with no interference with the professional relationship between physicians, dentists and patient, or between physician and hospitals.

4. It should place emphasis on community welfare and should be non-profit in operation. Surplus earnings, after safe reserves have been provided, should be used for the benefit of subscribers in the form of reduced premiums or increased benefits.

5. Benefits should be comprehensive.

6. The plan must be free of political control.

7. The setting up of an over-all governing board of control is proposed, consisting of equal representation of physicians, hospitals, industry and the public to administer a uniform plan of prepayment voluntary insurance covering medicine, surgery and hospitalization.

After further discussion, Doctor Cline reported that at the 195th meeting of the Executive Committee, held on September 26, 1945, the following modifications were suggested by the C.M.A. Executive Committee:

The mimeographed circular "The American Plan," submitted by George M. Wood, Chairman of Blue Cross Committee of the Association of California Hospitals was considered paragraph by paragraph and following tentative agreements reached in regard thereto:

(a) In the diagram, words "equal," "advisory," and "public" to be deleted. Word "Labor" to be inserted as



of equal importance as "Industry." Word "Agriculture" to be substituted for word "Public."

(b) In the subparagraphs under side heading, "*The plan proposes the following features,*" notations to be made as follows:

Paragraph (1), no change.

Paragraph (2), no change.

Paragraph (3), delete word "dentist" with addition of sentence, "When, as and if Dental Care is included, then equitable representation of the Dental Profession will be made."

Paragraph (4), place period after word "welfare" in first line. Delete remainder of the paragraph.

Paragraph (5), add words, "as possible," to then read "Benefits should be as comprehensive as possible."

Paragraph (6), no change.

Paragraph (7), delete word "equal." After word "hospitals," insert word "labor." Delete word "public" and insert in lieu thereof, word "agriculture."

\* \* \*

Tentative Agreement that it would be desirable to have a large Governing Board or Board of Directors say of 30 members composed of 6 members each, respectively representing the groups of (1) Physicians, (2) Hospitals, (3) Labor, (4) Industry, and (5) Agriculture. This body to meet several times a year.

\* \* \*

The Governing Board to elect an Executive Committee consisting say, of three physicians and two hospital representatives. This committee to be the active administrative head of the organization.

\* \* \*

Discussion followed on whether the three Blue Cross Plans now operating in California could amalgamate as one organization; or whether, that failing, the Association of California Hospitals would wish to bring a new statewide Blue Cross group into being (in conjunction, with or without one or more of the three existing California Blue Cross groups.)

#### 15. Legal Department:

Legal Counsel reported the present status of the Industrial Accident Fee schedule. The Council was informed that the Industrial Accident Fee Schedule Committee had approved modifications in the fee schedule previously submitted by the Association to the Industrial Accident Commission, these modifications being: home visits, \$2.50; hospital visits, \$2.50; double operations, one and one-half times the fee for a like single operation.

Counsel then recommended that the new fee schedule, as modified, be forthwith submitted to the Industrial Accident Commission, with a petition urging its adoption.

Counsel pointed out that under the reorganization bill recently passed by the Legislature, there are now seven members of the Industrial Accident Commission instead of three members, as was formerly the case, and that of these seven, three of the new commissioners reside in southern California. For this reason, Counsel requested permission to associate a southern California attorney in all matters before the Industrial Accident Commission.

On motion, seconded and unanimously carried, the recommendations of the Legal Counsel were approved, and the Executive Committee was authorized to arrange with Legal Counsel for the compensation of the Southern California associate attorney.

#### 16. Woman's Auxiliary:

Receiving comment were the following: A letter of October 15, 1945, from Mrs. Ralph Eusden, President of the Woman's Auxiliary to the California Medical Association, enclosing a letter of June 19, 1945, to Mr. Stanley Cochems, concerning *The Courier*; and a letter of

September 18th, 1945, to Mrs. Eusden from Mr. Cochems, and a resolution adopted by the Directors of the Woman's Auxiliary to the C.M.A. In the new arrangement, *The Courier* of the Woman's Auxiliary would be considerably increased in size.

#### 17. Instructions to C.M.A. Delegates to A.M.A.:

Doctor Dwight H. Murray, Chairman of the C.M.A. delegation to the A.M.A., reported that the delegates and alternates had been in session during the noon hour and had agreed upon general policies to be followed in relation to the meeting of the House of Delegates of the American Medical Association to be held in Chicago on December 3-6, 1945.

It was stated that Delegates Wilbur, McClendon, Murray, McLean, Askey, Cline, and Cass would be able to attend, and that Doctor Madsen, alternate to Delegate Goin, would also attend, thus completing the delegation of eight from the C.M.A. to the A.M.A. House of Delegates.

#### 18. Committee on Public Policy and Legislation:

(a) Doctor Dwight H. Murray, Chairman of the C.M.A. Committee on Public Policy and Legislation, made a brief report concerning the present status of legislative matters.

(b) A letter was read from Doctor A. J. J. Rourke, concerning Senate Bill 191, through which some five million dollars would be appropriated for a nationwide survey of hospitals. The Council voted to endorse S. B. 191.

(c) Mr. Read discussed Federal and State legislation, referring to the following items: Wagner Bill; Pepper Bill for extension of E.M.I.C.; the possible addition to the United Public Health League of the States of New Mexico and Wyoming; the Washington office of the United Public Health League; tours by Assemblyman Kraft to Alameda, San Mateo, Santa Clara, and San Francisco counties; possible special session of Legislature in December or January; and, obtaining opinions of legislative candidates on the subject of compulsory health insurance.

#### 19. Request from Physician in Del Norte County for a Component County Society Charter from the C.M.A.:

Request was received from Doctor Francis M. Stump of Del Norte County, for a county society charter for that county.

The information was given that Del Norte County had approximately 5,000 citizens, with three resident physicians. Attention was called to the by-law provision, Article V, Section 8, whereby issuance of a charter is vested in the House of Delegates, the Council having no authority.

#### 20. C.M.A. Cancer Commission:

The C.M.A. Cancer Commission, through its Chairman, Doctor Kinney, submitted the following:

The Cancer Commission submits the following progress report:

1. The Commission has decided to revise the Cancer Commission Studies of 1934 and prepare from that a cancer manual to be distributed to the physicians in the State. The editorial committee appointed consists of Dr. Leonard G. Dobson, Chairman, Dr. Clarence J. Berne, and Dr. Otto H. Pfeuger.

2. The Commission is attempting to organize a Cancer Committee in every county medical society in California. A bulletin has been prepared for each county committee outlining the functions of such a committee as visualized by the Commission.

3. The Commission is starting a preliminary survey of the cancer facilities in the State. A questionnaire has been

sent to each of the approved cancer clinics. A second questionnaire has been prepared to be sent to the Cancer Committee of each county medical society regarding the available facilities and needs in their county.

4. The Commission has appointed a committee consisting of Drs. Rinehart and Wood to contact the California Department of Public Health to discover the possible methods of coöperation between the California Medical Association and the Health Department in cancer control programs.

Dr. Wilton L. Halverson, Director of Public Health, has submitted a request to the United States Public Health Service to assign a medical officer to survey the cancer situation in California and advise him as to procedures. The Cancer Commission believes that the California Medical Association should join the Director of Public Health in this invitation to the United States Public Health Service to make a survey of the cancer situation in California. The Commission, therefore, respectfully suggests to the Council that they issue a request through channels to the United States Public Health Service paralleling the request of Dr. Halverson or that they direct the Commission to issue such a request in the name of the California Medical Association.

On motion duly made and seconded, it was voted that the recommendations submitted be approved and that the Cancer Commission be authorized to so inform the interested parties concerning a survey of cancer facilities in California.

#### 21. Committee on Rural Medical Service:

It was agreed that the Chairman of the Council should appoint a sub-committee on Rural Medical Service, in response to a request from the A.M.A. Special Committee on Rural Medical Service. (Chairman Gilman appointed the C.M.A. Committee on Health and Public Instruction for this service: Drs. J. C. Geiger, E. Earl Moody and C. M. Burchfiel.)

#### 22. Los Angeles County Medical Association Invites C.M.A. Council to attend its 75th Anniversary:

Secretary E. T. Remmen of the Los Angeles County Medical Association, and Speaker E. Vincent Askey, extended an invitation to the members of the Council and their ladies, to be the guests of the Los Angeles County Medical Association on the occasion of the 75th Anniversary of that county unit. The celebration will take place on Thursday, January 31, 1946.

On motion made and seconded, it was voted to accept with thanks the gracious invitation.

#### 23. Time and Place of Next Meeting:

On motion, it was voted that the next meeting of the Council should be held in Los Angeles on Friday, February 1, 1946.

#### 24. Executive Session:

The Council went into Executive session. It was agreed that action on the matters considered be deferred until the next meeting of the Council.

#### 25. Adjournment:

There being no further business, the meeting was adjourned.

PHILIP G. GILMAN, *Chairman*,  
GEORGE H. KRESS, *Secretary*.

Our country [America] has liberty without license and authority without despotism.

—James, Cardinal Gibbons, *Address*,  
at Rome, 25 March, 1887.

Intellectually I know that America is no better than any other country; emotionally I know she is better than every other country.

—Sinclair Lewis, *Interview in Berlin*, 29 Dec., 1930.

## COUNTY SOCIETIES†

### CHANGES IN MEMBERSHIP

#### New Members (25)

##### Alameda County (3)

Cholfin, Mollis, *Oakland*  
Footer, Wilson, *Oakland*  
Henley, R. Bruce, *Berkeley*

##### Merced County (1)

Buckley, John P., *Merced*

##### Orange County (2)

Thysell, Nels John, *Orange*  
Wickett, William H., Jr., *Fullerton*

##### Sacramento County (2)

Fanucchi, Dino W., *Sacramento*  
Iki, George S., *Los Angeles*

##### San Francisco County (14)

de Silva, Paul L., *San Francisco*  
Escher, Earl W., *San Francisco*  
Fenlon, Roberta F., *San Francisco*  
Garthwaite, Mary E., *San Francisco*  
Hillstrom, Earl M., *San Francisco*  
Howard, Frederick S., *San Francisco*  
Low-Beer, Bertram V. A., *San Francisco*  
Mendel, Robert A., *San Francisco*  
Musser, Don Carlos, *San Francisco*  
O'Gara, Louis A., *San Francisco*  
Salisbury, Peter F., *Berkeley*  
Schindler, Meyer, *San Francisco*  
Schmitz, William G., *San Francisco*  
Torkelson, Harold P., *San Francisco*

##### San Joaquin County (1)

Chope, H. D., *Stockton*

##### Yuba-Sutter-Colusa County (2)

Culiver, Norman, *Marysville*  
Edwards, D. Ermorine, *Marysville*

#### Retired Members (3)

Nuttall, John P., *Los Angeles County*  
Slemons, J. Morris, *Los Angeles County*  
Visscher, George, *Los Angeles County*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

## In Memoriam

**Boyer, Horace Russell.** Died at Glendale, November 10, 1945, age 68. Graduate of University of Maryland School of Medicine, Baltimore, 1903. Licensed in California in 1909. Doctor Boyer was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



**Breuer, Miles John.** Died at Los Angeles, October 14, 1945, age 56. Graduate of Rush Medical College, Chicago, 1915. Licensed in California in 1943. Doctor Breuer was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



**Cooper, Harold John.** Died at Fresno, November 5, 1945, age 51. Graduate of Stanford University School of



Medicine, Stanford University-San Francisco, 1921. Licensed in California in 1921. Doctor Cooper was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Desrosier, George Washington.** Died at Colusa, October 25, 1945, age 66. Graduate of Cooper Medical College, San Francisco, 1894. Licensed in California in 1895. Doctor Desrosier was a member of the Yuba-Sutter-Colusa County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Driver, Camilles Ogden.** Died at Los Angeles, August 2, 1945, age 48. Graduate of Rush Medical College, Chicago, 1922. Licensed in California in 1922. Doctor Driver was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Khuri, Kalim Basil.** Died at Hollywood, November 4, 1945, age 58. Graduate of Columbia University College of Physicians and Surgeons, New York, 1915. Licensed in California in 1939. Doctor Khuri was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

**MacMillan, John Kerr.** (Captain, Army of the United States.) Killed in Action, October 5, 1945, in Iran, age 37. Graduate of College of Medical Evangelists, Loma Linda, 1938. Licensed in California in 1938. Doctor MacMillan was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Parkinson, Sidney Nuttall.** Died at Piedmont, October 31, 1945, age 46. Graduate of University of Pennsylvania School of Medicine, 1926. Licensed in California in 1930. Doctor Parkinson was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Sagnella, Lawrence Alexis.** Died at West Los Angeles, October 29, 1945, age 45. Graduate of Tufts College Medical School, Boston, 1925. Licensed in California in 1935. Doctor Sagnella was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

**Waterman, Helen Jane.** Died at Berkeley, October 14, 1945, age 88. Graduate of Women's Medical College of Pennsylvania, 1897. Licensed in California in 1897. Doctor Waterman was a Retired Member of the San Francisco County Medical Society, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

**George Eliot (1819-1880).**—From the Journal and letters of George Eliot, born Mary Ann Evans, it is evident that she was never in robust health, a factor that often affected her writings. All the more credit to her that she contributed such outstanding novels to English literature as "Adam Bede" and "Silas Marner." Her death occurred after a brief illness, brought on by a cold and throat ailment, that she developed after sitting in a draft in an over-heated concert hall.—Warner's *Calendar of Medical History*.

## OBITUARIES

Henry Stanley Rogers

1884—1945



The difficulty of putting thoughts into words and onto paper is never more present than in writing about a friend all those things which were deserved but probably unmentioned during his lifetime. At such times our own shortcomings arise to confront us. Our only defense can be that we have tried in our friendship to express those sentiments which we have not put into words; those things which we felt but did not talk about.

The death of Henry Stanley Rogers came as a shock to many, an anticipated event to others and a release to Henry. In ill health for more than a year, he went to his reward while instructing his attending physician in the intricacies and technique of handling his own case. Never could he have better demonstrated the courage which constituted a large element of his character.

Henry Rogers, or Stanley as his family and some intimates called him, will never be rated as one of the great men of our time. His career did not lend itself to consideration of greatness but his steadfast character, his understanding heart and his normal courage were all elements which we seek in great men. To that extent, at least, we can call him great in his own small way. Born on a farm, educated in the manner of all other physicians of his time, he came out of medical school just in time to enter the Army Medical Corps in the first World War. Serving with distinction, not seeking or receiving much recognition in the way of military rank, he carried on his duties even in the face of a gas attack from which he saved his patients but could not himself escape. The results of that attack were to remain with him throughout his life and undoubtedly to contribute to his final illness.

At the war's end Henry and his wife, the former Jean DeHart, came to Petaluma, outlanders with a love of the soil and an ambition to do their best in the com-

munity of their choosing. Proof of their outstanding success in this endeavor came at Henry's funeral, where not one but many friends made the same comment, to the effect that there was not a better loved man in the community.

Zeal, where we find it, often expresses itself in various directions, and in Henry Rogers this was the case. His interests encompassed more than his own practice, his family, his home, his community. He early took an active interest in the professional, social and economic aspects of the practice of medicine. He brought into organized medicine the point of view of the rural man, the citizen of California who may be forgotten in a state which is preponderantly rural but dominated by large metropolitan areas. On the Council of the California Medical Association, Henry Rogers represented the sound judgment of the truly mature man, at the same time representing to a majority of metropolitans the cause of our many rural residents. His counsel was ever sound, honest and contributory to the common good. As President of the California Medical Association, 1941-1942, he displayed all the characteristics of leadership which his colleagues recognized in electing him to that post.

Henry will be missed throughout California. He will also be missed at Diamond Lake, Oregon, where his summer cabin and his bright red fishing canoe were known to all. In his fishing he exhibited the same skill, patience and canny understanding that he brought to his whole professional and personal life. His intimates will always treasure his friendship and remember him, his friends will miss him. We have all suffered a loss in his death.

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**John Dysart Dameron**  
1869—1945

On Tuesday, September 25th, the senior member of the San Joaquin County Medical Society, Doctor John Dysart Dameron passed away, after a lingering illness of several years' duration. Doctor Dameron was in his 79th year and had been practicing medicine in San Joaquin County since 1895, until his retirement several years ago. The Doctor was born in Prairie Hills, Missouri, June 11, 1867. He was graduated from the Missouri Medical College of St. Louis, Miss., now the Medical department of Washington University, on the 24th of March, 1894, and was licensed to practice in California in 1895.

In his earlier years in practice, Dr. Dameron was in charge of the San Joaquin General Hospital from the late nineties to 1912, at which time he built a private hospital in Stockton, which still bears his name, Dameron Hospital. During his long career he was primarily interested in surgery and earned a deserved and enviable reputation as a successful and bold surgeon. While at the San Joaquin General Hospital he began to close infected abdomens without drainage.

For many years he made regular trips to the Mayo Clinic and was a life long member of the Surgeons Club of Rochester, Minnesota.

In 1940 the San Joaquin County Medical Society met in a special dinner meeting held at the Hotel Wolf at which time Doctor Dameron was honored as the dean of the medical group of the San Joaquin County Medical Society. Seventy-two fellow practitioners, the largest gathering of medical men ever held in this county, paid him this tribute. His place will be hard to refill.

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**James T. M. Allan**  
1870—1945

On August 25th the medical staff of the California Hospital, in Los Angeles, lost one of its most loved members, Dr. James T. M. Allan. The death of this kind

doctor ended a service to the hospital almost as long as the history of the institution, itself.

In 1903 Dr. Allan was the sixth youngest doctor to serve an internship at the California Hospital and, upon the completion of that service, he immediately began the private practice in Los Angeles that was to continue until his death.

Mr. R. Ernest Lamb, who conducted the memorial service for Dr. Allan, described him as St. Paul described the Apostle Luke, by calling him the "Beloved Physician."

"Many are the number who knew him as a fellow physician, one whose counsel was sought and valued, one who always was true to his solemn responsibility as a follower of the medical profession. His desire to heal, and save lives, and to minister to the needs of those who suffered came from his heart. As a comrade in service, he will be remembered as the beloved physician.

"Many others sought him as a doctor and discovered that they found not only a skilled physician but a warm and faithful friend. He was a man of rich and abiding friendships. To those he will be remembered as the beloved physician."

In the hearts of many, the name of Dr. Allan means love and service for others. There is no one who can take his place. He was a beloved physician.

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**Edward S. Babcock**  
1898—1945



Edward Saunders Babcock died in Sacramento, on September 3, 1945, at the untimely age of 47, of complications incident to an essential hypertension. He practiced pediatrics in Sacramento for 20 years. Though born in Porterville, N. Y., he lived his early years in Riverside, California. Graduating from the University of California Medical School, San Francisco, in 1923, he served one year as intern at the University of California Hospital and one year as Resident Physician in the Children's Hospital of Oakland before commencing practice in Sacramento.

Doctor Babcock was a veteran of World War I. For 16 years he was consulting physician of the Sacramento Children's Home and he was a past president of the Sacramento Society for Medical Improvement. He was also a past president of the Northern District Medical Society. He was a member of the California Academy of Medi-



cine, the American Pediatric Society, Washington Lodge No. 4 F. and A. M., the Scottish Rite, the Ben Ali Temple of the Mystic Shrine and Royal Order of Jesters.

To those who knew "Eddie Babcock," his passing is more than a momentary shock. The children who were his patients, their parents, and his medical associates whose privilege it was to work with him will long remember his sterling character and unforgettable personality.

Certain indelible impressions come to mind as one recalls pleasant associations with this colleague. They emphasize his outstanding characteristics, as kindness and tolerance of others' opinions, and painstaking scientific thoroughness and truthfulness in the finest medical tradition.

In his professional relationships Doctor Babcock was particularly outstanding. He was a strong organization man and gave generously of his time to medical affairs, was a faithful attendant at all medical meetings and a valiant partisan in all things pertaining to the welfare of the medical profession and the ethical practice of medicine. He was especially considerate of younger men entering practice and was more than generous in guiding and advising them.

Doctor Babcock's family life was another fine and happy chapter and his home ever a haven of friendship, hospitality and good cheer. He is survived by his wife and three daughters.

No words can adequately describe the high fidelity and courage displayed by Doctor Babcock during the final months of his illness. In those last days he was ever calm and unshaken. At all times he was his usual friendly, kindly self, interested in others, in events of the day and never by word or gesture intruding upon others his own tragedy inevitably approaching.

To sum up our colleague whose passing was so untimely—he represented all that was fine and good as a doctor, a husband and father, as a citizen and as a man.

D. SCHUYLER PULFORD.

#### MEDICAL EPONYM

##### *Wilson's Disease*

The essay "Progressive Lenticular Degeneration: A familial nervous disease associated with cirrhosis of the liver" formed part of a thesis by S. A. K. Wilson (1878-1936). The monograph appeared in *Brain* (34:295-509, 1912), and the following is a quotation from pages 486 and 487:

"Progressive lenticular degeneration is a disease of the motor nervous system, occurring in young people and very often familial. It is not congenital or hereditary.

"It is progressive and fatal within a varying period; acute cases may last only a few months . . . the average duration of chronic cases in four years.

"It is characterized by a definite symptom-complex, whose chief features are: generalized tremor, dysarthria and dysphagia, muscular rigidity and hypertonicity, emaciation, spasmodic contractions, contractures, emotionalism. . . .

"Although cirrhosis of the liver is constantly found . . . there are no signs of liver disease during life. . . .

"The chief pathological feature of the disease is bilateral symmetrical degeneration of the putamen and globus pallidus, in particular the former. . . .

"A constant, essential and, in all probability, primary feature of the pathology of the disease is cirrhosis of the liver, not syphilitic or alcoholic."—R. W. B., in *New England Journal of Medicine*.

Life is not measured by the time we live.

—George Crabbe, *The Village*, Bk. II.

## CALIFORNIA PHYSICIANS' SERVICE†

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P. K. Gilman, M.D., San Francisco  
C. L. Mulfinger, M.D., Los Angeles  
Rt. Rev. Thomas J. O'Dwyer, Los Angeles

\* \* \*

### Executive Staff

W. M. Bowman, Executive Director  
A. E. Larsen, M.D., Medical Director  
W. H. Gardenier, M.D., Assistant Medical Director

### Beneficiary Membership

	October, 1944	October, 1945
Commercial Program.....	93,000	151,233
Rural Health Program .....	2,011	2,178
Housing Program .....	15,200	7,098
Total Membership .....	110,211	169,509

The Board of Trustees of California Physicians' Service held a regular meeting on October 20th, at the Town House, Los Angeles.

It was reported that the membership as of this date was approximately 170,000. Acquisition activities during the month of September showed an enrollment of 10,940 new members. This was offset by a loss of 4,731. This loss is heavier than has been reported in previous months, and represents the effects of reconversion and shifting labor conditions on the plan.

Under professional membership, there is still a steady increase in the number of physicians who are allying themselves with the organization, and as of the end of September, total professional membership reached 5,625. There is noticeable activity on the part of physicians returning from service. Individual calls are being made to these men, the history of C.P.S. during the time they were in service is being reported to them, and they are being brought up to date on its present status and current procedures. Many of these physicians have expressed a great deal of satisfaction with present conditions, and also with the improvement in the method of handling patients which has taken place since they last rendered service.

It was reported to the board that the professional membership generally has graciously understood the necessity for the \$2.00 unit value during the reconversion period. This is a factual demonstration of the support given by professional members of C.P.S.

Various phases of the actuarial status of C.P.S. were thoroughly discussed by the board, to see where other economies might be made. However, it was the consensus that at least six months or more experience under the new rates should be analyzed before any changes of this nature are made. It was also the consensus that the product which is now being offered to the public is excellently adjusted to the practice of medicine, and also provides a maximum of benefits to the beneficiary. These two principles, being the main objective of prepaid medical care plans, should be preserved.

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization through W. M. Bowman, Executive Director.

Of interest to the individual physician was a report of income under private practice, in a consecutive series of 100 cases, against income under C.P.S. for a series of 100 consecutive cases of a similar nature. The results showed a very satisfactory comparison, and on the basis of this report, it was suggested that the Council of the California Medical Association make an independent inquiry of a similar nature from physicians in the various specialties, in different areas of the state. The results of this should be of considerable interest.

The Public Relations Program is being geared more and more to the coming Public Relations Program of the California Medical Association. Several communities in the state have requested so-called "community programs," in which the physicians and local business have indicated their desire to join together and promote prepaid medicine in their communities.

The board was advised that notice had been given to the Marin Housing Authority to close Marin City as of November 30th. This has now been accomplished. In the interim, due to a sudden drop-off of membership in the Vallejo area, because of economic conditions relative to wages and the intensification of turnover in labor, notice has been given to the Vallejo Housing Authority that C.P.S. would discontinue in that area by the first of the year. This will constitute complete disappearance of this special program which was in effect during the war time period.

Negotiations are still under way, and progressing, to develop a new Rural Health Program which can more adequately reach increasing numbers of the farm population of this State.

The board was given current reports on the activities of the C.M.A. Study Committee, as well as the C.M.A. Advisory Planning Committee and the Hospital Association Committee.

The board authorized bonuses to employees at Christmas, in the interest of strengthening personnel relationships and rewarding loyal employees for their services to C.P.S. This applies to the general administrative staff, but excludes the executives.

Guests at the meeting were Mr. Mortenson, Secretary of the Retail Druggists' Association of Southern California, and Mr. Warnack, Vice-President of the California State Pharmaceutical Association. They indicated a desire to find a common ground upon which the pharmacists and physicians of this State could present a solid political front in mutual coöperation.

In the interim since the board meeting, the representative of the National Physicians' Committee, which is making a study of medical service plans throughout the country, spent several days at the C.P.S. offices in San Francisco. C.P.S. has also been visited by an actuary employed by the Assembly Interim Committee of the State Legislature. Both were given free access to information, and special information is being prepared, at their request.

CHESTER L. COOLEY, M.D., *Secretary.*

The less America looks abroad, the grander its promise.  
—Emerson, *Uncollected Lectures: Character.*

E Pluribus Unum. (One from many.)

—Motto, used on the title page of the *Gentleman's Journal*, January, 1692. Motto for seal of the United States proposed originally on 10 August, 1776, by a committee composed of Benjamin Franklin, John Adams and Thomas Jefferson. Adopted 20 June, 1782. The motto was added to certain coins in 1796. The actual selection of the motto has been claimed for Pierre Eugène du Simitière, a Swiss artist, who was employed by the committee, shortly after the Declaration of Independence, to submit a design for the seal—a design which was not accepted.

## CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

On Coöperation Between California State Office of Selective Service System and California P. and A. Service for Physicians

(COPY)

FEDERAL SECURITY AGENCY  
PROCUREMENT AND ASSIGNMENT SERVICE  
FOR PHYSICIANS—CALIFORNIA  
Field Office: Room 1331, 450 Sutter Street  
San Francisco 8, California

November 8, 1945.

George H. Kress, M.D., Secretary-Editor, *Addressed.*

I am enclosing a copy of a letter which might be published in the *Journal of the CALIFORNIA AND WESTERN MEDICINE* if you feel it advisable. It is of interest because it shows the fine coöperation the Procurement and Assignment Service as well as the Postwar Planning Committee of the California Medical Association is receiving from the various agencies involved in the relocation of veterans. The Procurement and Assignment Service and the medical profession has had the greatest help and coöperation from the State Office of the Selective Service System.

With my kindest regards, I remain,

Sincerely yours,

HAROLD A. FLETCHER, M.D.,  
*California State Chairman for Physicians,  
Procurement and Assignment Service.*

(COPY)

STATE OF CALIFORNIA  
DIRECTOR OF SELECTIVE SERVICE  
Plaza Building, Sacramento 14

October 16, 1945

Subject: Your Lettet re: \_\_\_\_\_

Dear \_\_\_\_\_:

The problem which you present concerning Dr. \_\_\_\_\_ has interested me considerably, inasmuch as it resulted in my learning of a number of activities engaged in by Procurement and Assignment, which activities I was not acquainted with until I made inquiry as a result of your letter.

My first impression was that a doctor such as Dr. \_\_\_\_\_, certainly has the right to settle in whatsoever spot he so desires to settle as long as it is in the jurisdiction of his licensure. I was certain that Procurement and Assignment could not "dictate the location of such a native son and veteran." Such is the fact. Procurement and Assignment cannot dictate the location of a doctor, but the Procurement and Assignment Service is still being asked by the California Medical Association as to the need of a doctor in specific spots and it is being asked for opinion as to whether it deems it fair and right that a particular doctor should switch his activities from a town where he once practiced to another town of his desire.

The reasons for approaching Procurement and Assignment for a recommendation with respect to a doctor's location are many. Apparently, first and foremost in the minds of those requesting such recommendation, is that of protecting the veteran physician who is still in the Army, and who, reasonably, should be assured that he may return to his old practice without having others



come in and take away his practice while he is helpless to protect it. Suppose we utilize the situation surrounding Dr. ——— as an example: Let us say that Dr. X, a surgeon who had builded a sizeable practice in ———, still remains in the service, and must so remain in the service for some six or more months. The question arises as to whether it is cricket for Dr. ——— to now move to ——— and establish a surgical practice which might prove to be detrimental to Dr. X's interests even after he returns. In other words, while Dr. X is helpless to return to ———, Dr. ——— enters ———, even though Procurement and Assignment feels that ——— is presently not in urgent need of another surgeon, and, likely, could not provide enough surgical practice for both Dr. ——— and the returning veteran after the veteran returned. Remember that the Procurement and Assignment recommendation to ——— Medical Society does not preclude the possibility of Dr. ——— going into ——— and establishing a practice even though such recommendation might make the ——— doctors unhappy if Dr. ——— did go to ——— despite Procurement and Assignment's recommendation that his entry there might upset the normal balance of medical needs.

By having made a 5-year study of the overall distribution of available medical care in California, Procurement and Assignment is recognized as being in an excellent position to advise where new doctors should locate as well as to advise concerning the justification (or lack of it) in the case of a doctor who wishes to dislocate from one area to locate in another. Since the California Medical Association recognized that the Procurement and Assignment Service had collected such extensive and important and guiding data concerning the medical needs of California, they approach Procurement and Assignment and ask them to act in an advisory capacity, and, it should be stressed that their recommendations are advisory only. This answers your question as to the legality of any policy dictated by Procurement and Assignment. With respect to dictating location, there is no legal basis.

There is probably a good reason why Dr. ——— has not yet heard from Dr. ———. Dr. ——— is involved only with the local set-up. When Dr. ——— receives a letter asking whether it is proper and right and in accord with needed medical distribution for one to settle in ———, Dr. ———, who is acquainted with the local survey, writes to the Chairman of Procurement and Assignment in California, gives said Chairman his best advice as to the need of the specific doctor desiring entrance into the community, and further advises the State Chairman concerning the time expectancy when doctors who have been established in ——— prior to entrance into the services will return. The State Chairman coördinates his local opinion with the picture as seen from the State level. Then, in turn, the State Chairman makes direct recommendation to the County Society concerning the need for the doctor, and discusses the right or wrong of the question as to his coming in prior to the return of those who expect to return shortly. Unquestionably, you recognize that such processing, followed by the Procurement and Assignment's report, would influence a local Medical Society as to the acceptance or non-acceptance of a member into its fold. To the extent of bothering by repetition, stress should again be put upon the point that whatever the decision the County Society makes would not bar the doctor from coming into the new location other than the bar which has been placed there by a lack of good will.

The reason why Dr. ——— has not had direct response from Dr. ——— likely may be laid to the delay caused by the processing from his office to the State Chairman and, then, back to the County Society.

If anyone should object to this method of attempting to properly distribute medical care to the population of the State, there is one great and saving point to such objection. It is as follows: The Procurement and Assignment Service has accomplished a magnificent job up to this time and, therefore, it is likely to continue to serve both the public and the profession well. From one who has had the opportunity to be closely acquainted with the work of Procurement and Assignment during the last five years, I can truthfully say that their task has been a difficult one, their work has been sincere and honest, they have made decisions without prejudice and those who abide by their decisions will not be led astray.

BERT S. THOMAS.

Colonel, MC.

State Medical Officer.

cc: Dr. H. A. Fletcher, Chm.,

P. & A. Service for Physicians

### New Discharge Setup

The soldier with a big family will be eligible to get out of the Army after December 1, regardless of his point score.

The War Department announced on November 16 a series of modifications to the present discharge system, including a reduction of point scores, which it said would add 783,000 men and women to the number eligible for release.

Later, the Navy announced point revisions for officers and enlisted men in previously "frozen" classifications which it said would qualify nearly 10,000 for release by January 1.

By December 1, the Army estimates it will have either discharged or have eligible for release, approximately 5,000,000 men. This figure will include more than 3,500,000 actually discharged and 1,483,000 eligible for discharge.

This will mean that of the 8,300,000 men in the Army on V-E day, 3,300,000 will be in service. The Army, however, is larger than that because of inductions and enlistments.

Men with three or more dependent children under 18 years of age will be eligible for release. Length of service doesn't matter. Previously 12 points were allowed for each such child up to a maximum of three.

The new point score for enlisted men will be 55, instead of the present 60. . . .

Male officers, except those in the medical department, will be able to ask for release if they have four years and three months' service. Their point score will be cut from 75 to 73. The Army said it would have an announcement before the middle of next month regarding discharge requirements for both men and women medical officers.

### Hoff General Hospital to be Closed

The Army's Hoff General Hospital, a city within itself, occupying 102 buildings and 56 acres, will close November 30, it was announced in Santa Barbara on November 1.

The first group of 350 civilian employees received civil service notice of termination of duties effective November 16. Officers explained patients will be transferred to other hospitals in the West between now and that date.

During the latter part of the month only a few officers and men were on duty to close the institution. In addition to the property inside the city the hospital operated a 15-acre farm and until recently used one of the largest elementary school buildings for special rehabilitation work.

### Navy Approves Monterey for Fleet School

A plan to educate thousands of officers for a powerful postwar Navy has been approved by Secretary Forrestal, and a board has recommended that the school be located at Monterey, California.

The Navy announced the plan on November 5, and officials said it would assure equality of opportunity to officers who have not graduated from the naval academy at Annapolis.

A board headed by Capt. H. A. Spanagel has recommended that the permanent school be located at Monterey, and that a temporary school be established at Quonset, R. I.

The general line school would consist of a one-year course. Naval officers emphasized that the school could not be considered a West coast equivalent of Annapolis.

Speculation as to where the Navy would establish the institution in the Monterey area centered around the Del Monte Hotel.

However, S. F. B. Morse, head of the Del Monte Properties Company, which operates the hotel, said the Navy had not committed itself to him.

The hotel and its extensive grounds have been used by the Navy since the very beginning of the war. It now houses a Navy radio school.

(Note. Hotel Del Monte in recent years, has been the place of choice for annual sessions of the California Medical Association. It had been hoped that the Navy would soon release the property to the Hotel Management.)

### Internal Medicine Conference at Letterman General Hospital

A conference on internal medicine was held at Letterman General Hospital in San Francisco, California, November 7 and 8, under the direction of Brigadier General Charles C. Hillman, Commanding General of the hospital, and was attended by medical chiefs, consultants, and surgeons of various hospitals and service commands.

Representing the Office of the Surgeon General, Brigadier General Hugh J. Morgan, Chief Consultant in Medicine, spoke on the rôle of medicine in the Pacific war and Major Clarence Livingood, Consultant in Dermatology, took part in a panel discussion of diphtheria and lichenoid and allied skin diseases.

Other subjects under discussion were rheumatic fever, coccidioidomycosis, and hepatitis. A program of dedication was planned for the new swimming pool at Letterman, and members of the conference were conducted on a tour of the hospital.

### World War II Casualties

Sixty-three per cent of the wounds received in World War II were those of the upper and lower extremities, with the lower extremities the heaviest proportion, according to Major General Norman T. Kirk, Surgeon General of the Army, who spoke recently before the Milwaukee Association of Commerce.

"There were 207,754 men of the United States Army killed in action and 571,490 wounded," General Kirk stated. "Of those wounded, 363,322 returned to duty after hospitalization and 25,145 died. These figures indicate that the rate of those wounded who died was nearly twice as great in World War I."

Of the 15,000 amputees of World War II, 14,000 needed artificial limbs, 7,000 of whom still remain in general hospitals. The balance either returned to civilian life or remained on duty as instructors for other amputees, the General continued. There have been two quadruple amputations and nine triple amputations re-

corded in World War II. Of the 14,000 needing prostheses, 95 per cent have lost one arm or leg, and five per cent have suffered two major amputations.

Outlining the Army's job in medical care and rehabilitation of the wounded, General Kirk also stressed the part of the American public in helping the returned veteran, and concluded, "Too many men in the last war became social derelicts because too little responsibility was assumed by business and industry in placement of the individual in a job commensurate with disabilities. Those men have won the war, now let us help them win the peace."

### General Somervell Reports on Army Medical Department

In his annual report to the Under Secretary of War and the Chief of Staff, General Brehon Somervell, Commanding General, Army Service Forces, made the following remarks concerning the Army Medical Department:

"The American Army is the healthiest army in history.

"Unbelievable strides have been made by Army doctors even as the war progressed, not only in surgery and care of the sick but in preventive medicine.

"Bold and successful use of sulfanamides and penicillin reduced the fatality rate of meningitis from 38 per cent in the first World War to three per cent in 1944, pneumonia from 24 per cent to 0.7 per cent, dysentery from 1.5 to only one recorded death. Deaths from malaria have dropped to an astounding low. In 1917-1919 there were 0.2 deaths per hundred cases . . . today the number is 0.06 per hundred.

"Great advances were made in the fiscal year in the uses of whole blood and penicillin. In North Africa the Army doctors discovered that blood plasma, although it did have a remarkably beneficial effect, could not substitute for whole blood in cases of the most severe shock. Blood banks set up in the United States sent 206,000 pints of whole blood to overseas theaters in nine months.

"Penicillin, for all its value, originally had shown a tendency to disappear from the blood stream after a few hours. In order to retain its effect, Army doctors worked out a method of suspending it in beeswax and peanut oil. Given hypodermically in this combination, penicillin remained in the blood for as long as twenty hours and destroyed disease germs.

"New methods of surgical care were perfected in the fiscal year. 'Phasing' of treatment was introduced. Care of the wounded was divided into three distinct phases. The first phase took place on the battle front, where surgeons and first aid crews gave emergency treatment. Patients then were evacuated, more swiftly than ever before, to hospitals in the Communications Zone. Much of this evacuation was done by air. It was not unusual for men who could be moved to undergo their emergency treatment within the sound of guns and eight or few hours later be in bed in hospitals five hundred miles behind the lines. There the second phase . . . 'reparative surgery' was undertaken. Again men were evacuated swiftly as soon as they were able to be moved safely to hospitals in the United States. Here the final phase of surgical reconstruction and rehabilitation was undertaken.

"The results are apparent in the lowest mortality rate in the history of any army in the world . . . 4.3 per cent of the wounded.

"DDT, the magic chemical produced in vast quantities for the Army, halted many plagues among civilian populations and prevented plagues in the Army by destroying insects and vermin. The entire population of Naples underwent DDT treatment, their clothing and bedding being sprayed, and dangerous epidemics were halted before they had a chance to spread.



"Inspection of foodstuffs is another duty of the Medical Department. Thirty-three million pounds of food were inspected daily at home and overseas.

"Forward steps in the neuropsychiatry treatments resulted in the return to duty in the theatre of operations of 90 per cent of the cases of battle fatigue. Forty to sixty per cent were able to return to combat units. Before the introduction of the new treatment, which occurs immediately behind the front, only ten per cent returned."

#### Army Personnel Receive Influenza Inoculations

All Army personnel have been ordered inoculated during the months of October and November with a new influenza vaccine as a preventive measure against influenza epidemics, the Office of the Surgeon General has announced.

The vaccine, made by injecting influenza virus into chick embryo, is to be administered in a single injection. Experimentation with the new vaccine was started early in 1943, but sufficient quantities for mass inoculation were not made available until the present year.

#### Army Medical Library Honorary Consultants Meet

The second annual meeting of Honorary Consultants to the Army Medical Library was held recently in Cleveland, Ohio, for the purpose of electing officers to the association. Among those attending were: Major General George F. Lull, Deputy Surgeon General; Colonel Harold W. Jones, former director of the Army Medical Library, retired; and Colonel Leon L. Gardner, present director of the Army Medical Library.

The following officers were elected: President, Dr. John F. Fulton; Vice-President, Dr. Chauncey D. Leake; Secretary-Treasurer, Colonel Harold W. Jones. Major General Lull was elected on the Executive Committee. The action taken by Congress toward erecting a new building for the Library was one of the main topics of discussion.

#### Art and Medicine

Realizing the contribution which the graphic arts have made to the historical and clinical study of medicine, the Army Medical Library is endeavoring to develop the picture collection which was begun many years ago. Largely through gifts, but partially through purchase, an accumulation has been made of anatomical drawings, pictures of medical institutions, instruments, and apparatus, posters publicizing public health drives, and maps for the use of sanitary engineers.

Society's attitude toward the practitioner is reflected in the etchings, engravings, and lithographs by some of the world's most famous caricaturists. The Army Medical Library owns original examples of the work of Rowlandson, Cruikshank, Hogarth, and Daumier.

When all the pictorial material of our most recent war has been gathered, it will serve as a valuable record of the problems which confronted contemporary surgeons and physicians.

The Army Medical Library's portrait collection includes some 10,000 photographs and prints. In it are represented the most famous medical men of all ages and all countries. Aesculapius appears, as well as Osler. The Library is anxious to continue to build its collection of portraits of persons prominent in the field of medicine and surgery. Individuals are being requested to send photographs to the Library. The collection of photographs of the Library's Honorary Consultants is not complete. If you are a member and have not already provided a photograph we will appreciate receiving one. It should be 8 x 10 inches in size, autographed, marked

on the back with your name, address, and the approximate date on which it was taken, and sent to: The Director, Army Medical Library, 7th Street and Independence Avenue, S. W., Washington 25, D. C.

Any other medical material you may wish to contribute to our picture, map or poster files will be gratefully received.

#### Veterans' Administration Medical Corps for Veterans

General Omar N. Bradley, administrator of veterans affairs, on October 20, pledged the creation of a separate medical corps for veterans and expansion of present veterans' hospital facilities.

General Bradley told the convention of Disabled American Veterans a construction program of hospitals and medical centers for veterans requiring continued medical care is in prospect.

He said the veterans administration now needs 1,300 more doctors and more than 500 specialists.

#### Will Offer Inducements

"Some doctors have told us they will come with us if we can offer them more attractive salaries, chances for professional advancement and the opportunity to practice modern medicine," he said.

"We mean to provide all three."

General Bradley said these inducements had been incorporated into recommended legislation which would create a medical corps in the tradition of the army, navy or the public health service.

"Emergency expansion of existing hospitals is inadequate," he said. "We now have 83,000 beds—including 11,000 emergency ones set up in present facilities—but we need 105,000 permanent beds with adequate personnel to man them."

#### "Reforms" in Veteran Medical Setup

As a result of an experiment successfully operated in Monmouth County, New Jersey, the Veterans' Administration hopes soon to authorize veterans suffering from service-connected disabilities to receive treatment from qualified doctors of their own choice within their own communities, instead of at Government clinics exclusively.

This program, marking one of several radical changes in medical practice within the Veterans' Administration, was outlined on November 10 by Major General Paul R. Hawley, Surgeon General of the Veterans' Administration, to the medical board of advisors of the American Legion.

General Hawley listed other "reforms" including payment of fees to specialists who will act as consultants at veterans' hospitals, development of specialized teaching at two and later three general hospitals for veterans, and institution of a rotation system for men who attended these courses of specialized instruction.

He also said plans are being made to set up an airplane ambulance service, such as was used by the Army abroad, to take emergency cases needing specialized care from remote hospitals to those equipped to give the needed service.

#### Near Crisis in Veterans' Hospital Program

General Omar N. Bradley, veterans' administrator, believes a record total of 81,000 veterans in hospitals have caused a near-crisis in the government's hospitalization program which can be solved in the immediate future only by overcrowding beds.

On a one-day visit to San Francisco, on October 18, the former commander of the 12th Army Corps in the European theater told a press conference that a gradually in-

creasing building program was under way. The government plans to be taking care of from 200,000 to 250,000 veterans in 20 years, he said.

The main concern of veterans' hospitals now, Bradley said, could be summed up as "shortages."

"There is a shortage of space, beds and personnel," he said, "and there are more veterans waiting than come in." It is a question of overcrowding or not having beds at all."

He said hospital records since the end of the First World War showed a peak number of patients is reached 20 years after hostilities cease. He pointed out, however, that gas attacks of World War I were responsible for most hospital cases following that war. Absence of poison gas warfare and improved medical treatment in this war have resulted in "a larger number saved," he said. . . .

He said the administration hoped to relieve the shortage of doctors through a Senate approved bill now before the House which would increase the number of physicians under civil service and provide part-time doctors by connecting the veterans hospitals with medical centers.

#### **All But 11,000 Army Doctors to be Released by Next June**

Army doctors are being released faster than the Army is reducing its total strength, in spite of the large number of battle casualties still remaining in hospitals and the requirement of doctors for separation center work, according to Major General Norman T. Kirk, Surgeon General of the Army, who spoke recently in New York in appreciation of the services rendered by member hospitals of the United Hospital Fund of New York.

"The peculiar situation that we find ourselves in is that demobilization, in which everyone is concerned, cannot proceed without the help of thousands of doctors—2,000 of whom are devoting their medical services solely to separation centers," General Kirk said. "By the first of January more than 14,000 doctors will have been returned to civilian life, which is more than one-third of the total number of doctors comprising the Army Medical Corps at its peak. By June of next year we anticipate releasing all but 11,000 doctors."

General Kirk, stating the peak hospital load in the United States to be 318,000, pointed out that there is still a need for medical personnel and that "one of our greatest problems is to hold enough doctors in the service to give the maximum medical care to our patients."

"I want to assure you," General Kirk concluded, "that, first, the Army Medical Department is going to continue to give to the sick and wounded soldiers of this war the best medical care known to science, and secondly, that it is going to return to civilian life as rapidly as possible every Medical Department officer whose services are not essential to the Army."

#### **Army to Release 23 Hospitals by January 1**

Release by the Army of 23 hospitals out of its wartime peak of 65 by January 1, 1946, has been announced by Major General Norman T. Kirk, the Surgeon General.

These hospitals will be offered to the Veterans' Administration or back to their former owners in the case of leased properties.

Additional hospitals will be released after the first of the year, but the schedule for such release cannot be forecast at this time, General Kirk declared. "As the number of men being cared for in any hospital decrease to the point where it is uneconomical to maintain it as a separate institution, the patients and facilities are consolidated into more efficient and workable units," he explained.

The peak patient load of hospitals in the United States, reached at the end of June, 1945, was 318,000, and has been dropping slowly ever since, despite the influx of men from overseas theaters, which was more than compensated for by hospital discharges.

The Medical Department estimated that by January 1, 1946, this total will have declined to about 220,000 patients, and that by June of 1947 there will be only 70,000 men remaining in Army hospitals.

Among hospitals to be released are the following:

DeWitt General Hospital, Auburn, California—December 31, 1945;

Hammond General Hospital, Modesto, California—December 21, 1945;

Hoff General Hospital, Santa Barbara, California—November 10, 1945;

Torney General Hospital, Palm Springs, California—November 10, 1945.

#### **Army Specialized Training Program for Medical Students to be Liquidated**

Medical students now in the Army Specialized Training Program, which is undergoing gradual liquidation, will continue training through the current fiscal year, ending June 30, 1946, with the future of the program depending upon requirements for medical officers, which will be reconsidered at that time, according to an announcement by the War Department.

#### **Army Doctors Make Over One Million Physical Examinations During October**

Over 1,250,000 physical examinations of Army officers and soldiers being demobilized in the United States were completed by Army doctors during October, according to Major General Norman T. Kirk, the Surgeon General.

The two thousand Army doctors assigned to separation centers alone completed examinations of 757,433 men during this period. In addition, Army doctors are assigned to other separation offices.

It is the policy of the Army, General Kirk said, to see that every man being released from the service is given the ultimate medical care before returning to civilian life. In addition, he pointed out, in order to speed demobilization, the complete physical examination has been so planned that the average soldier is processed by eight different doctors in one hour from the time the first doctor sees him, provided he has no ailment.

In this chain of medical examination he is looked over by a dentist, eye specialist, ear, nose and throat specialist, orthopedist, surgeon, urologist, and internist. Finally an overall medical officer, who has before him the reports of all preceding examinations, including all x-rays and laboratory tests, with the exception of serology, determines his physical condition. If it is necessary the man is referred to a ninth doctor—a psychiatrist.

#### **Army Lowers Doctors' and Nurses' Score**

Washington, Nov. 30.—(UP.)—The War Department today announced further reductions in the discharge score for Medical Department personnel. It said this would make an additional 15,000 physicians and 5,000 dentists eligible for discharge.

The discharge score for doctors and dentists was reduced from 80 points to 70. Also, they will become eligible for release after 42 months of honorable service or if they are 48 years of age to the nearest birthday.

The critical point score for nurses was cut from 35 to 25, and the discharge age from 35 to 30. Nurses now will be eligible for discharge after two years of service.



Those on duty in the United States classified for limited service also become eligible for discharge. It was estimated this would make 12,500 nurses eligible for discharge in addition to the 27,000 already qualified. Twenty-two thousand nurses have been discharged so far from the peak strength of 57,000.

Since V-E Day, 15,000 physicians and 3,500 dentists have been released. Peak Army strength was approximately 45,000 physicians and 15,000 dentists.—San Francisco *Chronicle*, December 1.

### War Department Reports New Discharge Regulations

Washington, Nov. 30.—(AP.)—The War Department today announced discharge requirements for plastic surgeons, eye, ear and nose specialists, orthopedic surgeons and internal medicine specialists, will be eighty points or continuous service since Pearl Harbor. A requirement of seventy points or forty-five months' service is fixed for gastroenterologists, cardiologists, urologists and other specialists. . . .—San Francisco *Examiner*, November 30.

### General Bradley Plan for Veterans' Hospitals is Supported

Washington, Dec. 2.—(UP.)—Major General Paul R. Hawley, acting Surgeon General of the Veterans' Administration and former Chief Army Surgeon in Europe, has threatened to quit—"and quit at once"—if Congress refuses to go along with General Omar N. Bradley's plans for veterans' hospitals, it was learned tonight.

Hawley wrote a blunt defense of Bradley's program to Representative Edith Nourse Rogers (R., Mass.) during last week's flareup over a \$158,000,000 deficiency appropriation to build new veterans' hospitals.

The major fight is over Bradley's reluctance to take over surplus Army and Navy hospitals in the congressional constituencies. Hawley wrote Mrs. Rogers, member of the Committee on World War Veterans' Legislation, that it was impossible for General Bradley to operate most Army and Navy hospitals because they were so isolated that doctors are unobtainable.

"I, for one, will not experiment with the medical care of the veteran. Either he gets the quality of medical care that he deserves, or I quit."

He said that the Veterans' Administration now employs 2,327 doctors, only two-thirds of those it needs to man 71,000 existing beds. Three-fourths of these are medical officers subject to release from the service.—San Francisco *Chronicle*, December 3.

**Military Clippings**—Some news items of a military nature from the daily press follow:

#### "Give Us Back Our Doctors," Cries U. S.

(First of three articles on the discharge of doctors in the service by Frank Astom, Scripps Howard staff writer.)

Washington, Oct. 29.—Across the country the cry rises: "Give us back our doctors. Get them out of uniform. We are desperate. Suppose we had an epidemic."

The military responds: "In medicine, the war is not over."

Demand for speedier releases is expressed formally by the American Medical Association. It springs alike from civilians and from some uniformed doctors.

The Army and Navy say: "We are fully aware of civilian needs. We are releasing doctors as rapidly as we can."

Against this crowds a common charge: "It should have been faster."

The Army expects to discharge almost 17,000 by January 1, the Navy about 4,000. The services insist the pace of doctor dismissal is getting faster all the time.

#### "Not Fast Enough"

Civilians retort: "It still isn't fast enough."

The Army obtained about 45,000 men, the Navy about 13,000 from the 165,000 who were practicing in 1941. Both services asserted they never had enough doctors.

The medical services point proudly to their records:

In World War II, only four of every 1,000 battle wound cases died after reaching hospitalization. This was half the toll of World War I. The death rate from disease in World War II was 1.2 per 2,000 per year. This was a drop from 38 per 2,000 in World War I and from 130 in the Civil War.

But civilians argue: "The war is over. Release our doctors."

Since V-E Day, the Army has released about 7,000 doctors, the Navy about 1,000. Following V-J Day, both services set up a community hardship system to return critically needed practitioners. . . .

It takes about a month to complete a hardship discharge.

Complaints from doctors in service run to this effect: "I haven't anything to do. I'm forgetting what I knew about medicine. My hands are getting stiff. I'll have to take a refresher course before I resume practice."

The services comment: "Until about a month ago we did have a bottleneck of overseas medical men. But now they're returning in enormous numbers as we assign young replacements. We still need doctors to attend wounded and sick men and to serve at demobilization points. We will not neglect the men who won the war." . . .

The American Medical Association reports that it is sympathetic with the Army and Navy, but it contends that doctors should be demobilized more rapidly. The A.M.A. says it receives letters from members in uniform complaining about idleness and slow demobilization.

As the Association sees it, the demobilization troubles lie in faulty administration.

The Army and Navy maintain: "Our prime duty is to our wounded and sick. And the health of the rest of the men must be protected."

At the same time, the services conceded that some of their doctors may sometimes twiddle their thumbs for lack of medical practice.

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The Army admits some of its doctors may be twiddling their thumbs at times. The Navy claims the physicians it retains are military necessities.

Both services report they are demobilizing doctors as rapidly as possible, consistent with safety to military health.

The American Medical Association says that isn't fast enough. The sentiment is echoed by various civilians and by many uniformed doctors.

6 to the 1,000

Here is the Navy's story:

"The Navy had 932 doctors before the war and 13,800 in July, 1945. We never had enough. By October 8, we had reduced our doctor count to 12,586.

"The Navy tried to provide three doctors for every 1,000 men. In combat that percentage was increased. By January 1 we expect to demobilize 4,000 doctors from the Naval Reserve. As of November 1 we are discharging doctors with 53 points.

"Wounded Navy men are still coming home from overseas. Some cases we dare not move. There will be a heavy patient load for some time. Moreover, we still have a good-sized personnel over whom doctors must keep medical watch.

"We shall discharge doctors as we discharge other personnel. We want to get our doctors back to civilian service as soon as possible.

"The Navy expects to have 3,000 to 4,000 doctors in its peacetime set-up."

Here is the Army's story:

"All Army doctors may not be fully employed today. Some are on duty with occupation forces. Some are on leave. Some who worked for Federal institutions have been discharged but cannot resume their work until their 45-day leaves expire because they are not allowed to draw both Army and Government pay. Others are in the process of being reassigned. . . .

Navy's Story

"On the other hand, our front-line surgeons and physicians, particularly with the infantry, performed prodigiously. They operated and treated under incredible conditions and carried a back-breaking load. We tried to provide 6.5 doctors for every 1,000 men. But in most combat areas that would not have been enough.

"After fighting stopped, most overseas doctors were busy sending the wounded home. After most of the wounded had been returned, many of the doctors remained

abroad. But today they are coming back fast. Most occupation doctors complain that healthy men on police duty provide them too little practice. But the Army won't rob its men of medical protection. . . .

"The Army is exerting every effort to hurry doctors back to civilian service. Some may be cooling their heels on occupation duty and a few may have little to do while awaiting reassignments. But there is more than enough work for all of them."

To this the American Medical Association responds: "Demobilization of physicians should be faster. We feel that there is a weakness in the administrative system of the service."

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The American Medical Association wants the Army and Navy to rush service doctors home.

The service took about 60,000 doctors from civilian life. That was almost one-third of the total number active in 1941. It meant that home-front physicians had to handle an increased amount of work. It meant also that civilian health was not always guarded adequately.

Army and Navy report they are doing all they can to speed release of doctors.

#### Ask Quicker Action

But the A.M.A. says:

"Our reports indicate the Army and Navy are not being as prompt as they might be. We feel that doctors should be returned more rapidly to improve civilian protection and lighten the burden of physicians who served at home.

"Our information is that too many service doctors are being held where they are not vitally needed. Doctors themselves report this. Many are eager to get back to work

"Men complain that they are in danger of losing their skill. A great number will insist on refresher courses. That would take time and deny medical service to civilians just that much longer." . . .

The Association's records show there were 201,272 physicians in this country at the outbreak of the war. All of these were not practicing at that time. The A.M.A. estimates about 165,000 were active in December, 1941. To help in the crisis, some old practitioners resumed, but the younger man carried most of the load. . . .

Thus civilians complain and the military explains. Inquiry into both sides reveals:

#### Some Are Idle

That here and there some military physicians are idle at times.

That demobilization slows down on occasion, leaving doctors and other service people temporarily stymied.

That the military refuses to discharge doctors at what it considers the peril of wounded or sick servicemen or of those to be demobilized.

That demobilization will require services of thousands of doctors well into next summer.

That, in medicine, the war is not over.—San Francisco News, October 31.

#### Colonel Lee, Out of Army, Crusades For Public Health Calls Medical Corps Set-up "Antiquated"

Dr. Russel V. A. Lee, not yet out of uniform although he has received his discharge and arrived home on terminal leave, took time out yesterday from greeting former associates at the Palo Alto Clinic to blast the "unfortunately antiquated organization of the army medical corps." And at the same time praise the caliber of army doctors and the "wonderful preventative medicine program" developed during the war.

The Palo Alto physician, who has retired with the rank of colonel after three years in service, revealed that he had written the original proposal of the bill advocating the creation of a national department of health that will be introduced in the Senate later this month.

The bill calls for the establishment of the office of secretary of national health, who would have cabinet status, and of a Federal department that would coordinate all government health agencies.

"Public health, after all," said Dr. Lee, "is as important as the postoffice."

Dr. Lee's most recent assignment was in Washington, D. C., as chief of preventative medicine for the U. S. Army Air Forces. Under his direction the air corps developed the unit that sprays DDT, the insect killer, over large areas.

#### Flu Vaccine Developed

Also under Dr. Lee's direction was the first large scale experiment with the new influenza vaccine, which appears

destined to place flu on the list of preventable diseases and gives new hope that other diseases caused by a virus also can be prevented at some future date. Infantile paralysis, he said, may fall into this class, as the virus that causes polio is very similar to the influenza virus.

"In Denver last summer we gave shots of the influenza virus to 20,000 air corps personnel. On the basis of the experiment's success the army as a whole is being immunized, starting October 1."

The DDT plane that sprayed Rockford, Ill., the city threatened with a polio epidemic early this fall, was from Dr. Lee's experimental unit. The disease dropped off, he said, but results, so far, are considered inconclusive. Planes also were used to spray a large area of the Panama Canal zone with the resulting death of 98 per cent of the mosquitoes in the area.

Dr. Lee's army experience was an enriching one, he said, but the great majority of army doctors were not so fortunate.

The doctors who volunteered to serve with high ideals of patriotism were bitterly disappointed in the out-of-date organization of the medical corps, and consider their years in service "a waste of time," he said.

"I do not mean any personal criticism of the surgeon general," explained Dr. Lee, "but definite revisions of the military organization should be carried out to prevent the waste of personnel that existed during the war."

"Army doctors on the whole are bitter and unhappy because they were not given enough medicine and were often placed in administrative jobs. No other groups is as anxious to get out of the army," he continued.

While the civilian population suffered from lack of medical care, there wasn't enough work to go around in the medical corps, Dr. Lee declared.

#### Civilians Neglected

"Except for battle wounds, it was much safer to be a soldier than a civilian during the war," he went on. The army, he claimed, had six and a half doctors for each 1,000 men, while civilians had but one doctor to each 1,700 persons.

"The medical corps apparently does not realize the potentialities of army transportation for doctors," said Dr. Lee. "The use of air travel would make it possible for doctors to be kept in a central pool and flown where they are wanted when they are needed."

Army reserve doctors show little desire to stay in the corps or even to keep up their reserve status, the surgeon said. He believes that the army will have to make immediate improvements to make the service more attractive, and suggested the following:

The providing of better professional opportunities by giving doctors more interesting work in large general hospitals.

More rank from the start and faster promotions. Dr. Lee pointed out that young medical graduates with eight years of study behind them are commissioned first lieutenants, while a surgeon whose private practice brings in \$50,000 a year may be made only a captain or major.

Dr. Lee's army experience left him with a high opinion of the type of young doctor the medical universities are turning out today.—Palo Alto Times, October 12.

#### Establishment of Hospitals For Veterans

A Bulletin of the Veterans administration gives the following information:

1. The 19 hospital locations, which General Bradley, Administrator of Veterans' Affairs announced on October 18, 1945, are only a part of the program, and many new hospitals containing thousands of beds will be announced upon approval by the President.

2. The policy is to locate hospitals where the veterans will receive the maximum benefit from the most modern medicine and surgery of the type now available only to wealthy (or charity) patients at certain nationally known medical centers.

3. Generally speaking, the benefit received depends primarily upon the type of medicine provided and not upon the buildings housing the patients. First-rate medicine can be provided only by first-rate specialists.

4. There are insufficient top-flight specialists available to staff expanding Veterans' Administration hospitals. Therefore, the services of this limited number of men may be obtained on a part-time basis only and only at the places where they are available, which are near the leading teaching centers. These are where the new large veterans hospitals should be located if the maximum benefits are to be provided.

5. Much of this new policy results from the number of veterans being about five times as great as before



World War II. Where 4,000,000 veterans were potentially available before, there are now almost 20,000,000.

6. This requires the policy to be to bring the veterans to the hospital itself, reversing the World War I idea of bringing the hospital to the veterans.

7. This does not entail, however, the abandonment of existing hospitals or preclude the building of small local hospitals for the convenience of veterans and visiting families. It will provide a type of treatment which may well mean the difference between recovery or death for thousands of seriously ill or injured veterans.

8. The interests of the veterans themselves, rather than of communities desiring veterans hospitals required the adoption of the present policy.

9. As part of the program announced by General Bradley for the construction of 19 new Veterans' Administration hospitals with a total of 11,100 beds, 13 of these hospitals with 9,550 beds are located near medical schools.

Funds for the new hospitals and additions are being requested for the current fiscal year (1946). They are part of the overall 29,100 bed program approved by President Truman on August 4, 1945. The remainder of the program, which will be announced later, will be requested for the 1947 fiscal year.

## COMMITTEE ON ORGANIZATION AND MEMBERSHIP

### Conference of Presidents and Other Officers of State Medical Societies

The first annual conference was held on Sunday, December 2, 1945, in the Tropical Room, Hotel Continental, Chicago.

#### PROGRAM

Presiding: A. S. Brunk, M.D., Detroit  
Chairman of Presidents, Twenty-five States  
2:30 P.M.

Report of Committee of Ten (Executive Committee of Presidents, Twenty-five States)—H. H. Bauckus, M.D., Buffalo, N. Y., Secretary.

Presentation of Resolutions—Appointment of Committees.

3:00 P.M.

The Challenge—"How Can We Assure Adequate Health Service for All the People?"—Arthur J. Altmeyer, Washington, D. C., Chairman, Social Security Board.

How the Medical Profession Can Answer Today's Challenge—"Expansion of Voluntary Group Health Care Programs"—Joseph H. Howard, M.D., Bridgeport, Conn., President, Connecticut State Medical Society.

"Health Legislation Beneficial to the People"—Philip K. Gilman, M.D., San Anselmo, Calif., President, California Medical Association.

"Modern Medical Public Relations"—O. O. Miller, M.D., Louisville, Ky., Past-President, Kentucky State Medical Association.

"Formation of a National Health Congress"—John F. Hunt, Chicago, Ill., Vice-President, Foote, Cone & Belding.

5:00 P.M.

Round Table Discussion—Leader: E. J. McCormick, M.D., Toledo, Ohio, Past-President, Ohio State Medical Association.

Reports of Committees.

6:00 to 7:00 P.M.

Presidents' Reception—Host: The Michigan State Medical Society.

Acknowledgment: The California Medical Association and the Michigan State Medical Society for Joint Sponsorship of Program.

## COMMITTEE ON PUBLIC RELATIONS

### A.M.A. Public Relations Conference in Chicago

Specific recommendations for definite action resulted from the first A.M.A. Public Relations Conference held under the direction of the A.M.A. Council on Medical Service and Public Relations in Chicago October 19-20.

Developed along new lines, it was a sort of "grass roots" affair with 115 representatives registered from thirty-five states and the District of Columbia. A high point of the Conference, of course, was the talk by Major General Paul R. Hawley, Medical Director of the Veterans' Administration. Informal, frank, pointed, tied together with keen bits of midland humor, it left a fine impression. He has a tremendous job, but no one who heard him had any doubt as to his ability to tackle such a tough problem.

Following a quick getaway briefing by E. J. McCormick, M.D., chairman, on the first day, the Conference was streamlined to produce definite results into seven informal round table discussion groups under seven moderators. On the second day each moderator prepared a round-up report on each round table embodying definite recommendations to be worked up by the Council for presentation for action by the Board of Trustees and the House of Delegates of the A.M.A.

As soon as possible these recommendations will be published in *J.A.M.A.*

Definite recommendations were made in regard to:

1. Prepayment plans.
2. E.M.I.C. program.
3. Fourteen point program.
4. Placement of Returning Medical Officers.
5. Publicity and Public Relations.
6. Veterans' Administration.
7. Rural Health.

#### PREVIEW OF CONFERENCE RECOMMENDATIONS

##### *On the Fourteen Point Program:*

Note. The 14 Point A.M.A. Program appeared in *CALIFORNIA AND WESTERN MEDICINE*, August, 1945, page 62.)

With reference to Point No. 1 relative to better living conditions, "We recommend constant publicity on the facts of this particular problem through the A.M.A., the state associations, the county societies, and the women's auxiliaries, by addresses and articles not only in the medical journals but also in the lay press."

For Point No. 2 concerning preventive medicine, "The implementing of this second point is by means of legislation. Such legislation should also be of interest to the A.P.H.A., the State and Territorial Health Officers Association, and the U.S.P.H.S. We recommend that the A.M.A. sponsor a conference with these groups in an endeavor to enlist their cooperation in legislative efforts to accomplish the purpose of this item."

"And on Point 14 referring to Veterans' Administration and U. S. Public Health Service, "Free choice of physician for all veterans under the care of the Veterans' Administration and integration into the voluntary plans of hospitalization and medical care."

##### *On the E.M.I.C. Program:*

"That the present Medical Advisory Committee to the Children's Bureau is not truly representative of the entire medical profession. Any program of that Bureau must be administered through the States' Medical Associations, and they should be represented."

"That the present advisory steering committee to the Children's Bureau be abolished and a new committee be

established which shall consist of one representative from each state medical association . . . and such other medical organizations as have a direct interest in the functioning of the Bureau."

"That since the Children's Bureau is not properly related to the Department of Labor, it should be transferred to the Federal Security Agency until such time as all health and medical activities of the Government are segregated into a single department."

#### *On the Placement of Medical Officers:*

"That all discharged medical officers be given terminal leave pay at the termination of their active duty and prior to the expiration of such accrued leave as they may have, thus enabling them to participate immediately in the benefits provided by Public Law 346 (78th Congress, G. I. Bill of Rights). Such a procedure will enable the returned medical officer to commence immediately his training in hospitals or medical schools after leaving the armed services."

"It is recommended that the Council on Medical Education and Hospitals be urged to set up at once a method for the more prompt approval of hospitals for residencies and consider the advisability of giving some temporary approval until formal inspections can be made."

\* \* \*

#### *A.M.A. Advisory Committee on Prepayment Medical Care Plans:*

The Council has approved the appointment of an Advisory Committee to direct the work on Prepayment Medical Care Plans. The Committee will be composed of various plan directors and others interested in this problem. It will have the duty of setting up a program for gathering regular monthly or quarterly data on the plans; for analyzing such data, and reporting back to the plans or to medical societies interested in starting plans. An organization meeting will be held at the A.M.A. headquarters at the earliest possible date.

\* \* \*

#### *Health Council Plans on Local Level:*

The Community Health Council idea as a medium for public relations and to assist in activating health programs seems to have a promising future. Until recently Health Councils have generally been local medical society projects. Dr. John Fitzgibbon has emphasized the importance of such Councils in the statement: "Most public health problems could be satisfactorily solved at the local level if local medical societies would assume the leadership in a plan of coöperative effort with other interested local organizations and agencies with whose leaders friendly relations were easily made or already existent."

Another program just instituted, and which presents a different and interesting approach to the problem, is that of the Michigan Health Council. This is not an effort solely by the doctors of Michigan but represents the combination and coördination of their influence and support with that of other organizations of the state which have a common interest. The Council was incorporated a year ago as a joint organization of the Michigan State Medical Society, the Michigan Hospital Association, Michigan Service and Michigan Hospital Service.

### **Reports on Proposed Laws Related to Public Health Activities**

A report upon certain bills now pending before Congress.

#### *Wagner-Murray-Dingell Bill—S. 1050:*

The Senate bill is still with the Committee on Finance while the House bill is with the Committee on Ways and

Means. Neither Committee has manifested any intention of early consideration of the bills, but Senator Wagner says he expects to have hearings upon his bill held in the near future.

#### *Hill-Burton Hospital Bill—S. 191:*

The subcommittee of the Senate Committee on Labor and Education has rewritten S. 191 and reported it out to the Full Committee a week ago. Today the Full Committee reported it to the floor of the Senate. Among the important features of the bill are—

1. Instead of appropriating \$100,000,000 for construction for the fiscal year ending June 30, 1946, the new bill provides \$75,000,000 each year for the first five years beginning the fiscal year of 1947.

2. The formula for allotment to states has been changed so that allotments will range from 33 1/3 per cent to the most wealthy states to 75 per cent for the poorest

3. The Surgeon General is instructed to prepare within six months, with the approval of the Federal Advisory Council and the Administrator, general regulations with regard to the

- a. Number of general hospital beds that may be constructed in any specific area.
- b. Specialized hospital beds.
- c. Number and distribution of public health centers.
- d. General manner of determining priority of projects.
- e. General standards of construction and equipment.
- f. Prevention of discrimination on account of race, creed or color.

4. Ten specific instructions are outlined for preparation of plans by the States. Briefly stated they are:

- a. Designate a single agency to administer or supervise administration of the plan.
- b. Show that this agency will have authority to carry out the plan.
- c. Provide for an advisory council to consult with the agency.
- d. Set forth a hospital construction program to be based on a survey of needs.
- e. Set forth the relative need for projects and provide for their construction.
- f. Provide methods of administering the plan.
- g. Provide minimum standards for maintenance and operation of hospitals which receive Federal aid under this title.
- h. Provide for an opportunity for a hearing before the agency to every applicant for a construction project.
- i. Provide that the agency make such reports from time to time as the Surgeon General may require and give him, upon demand, access to the records upon which such information is based.
- j. Provide that the agency will from time to time review its hospital construction program and submit to the Surgeon General modifications it deems necessary.

5. The definition of public health center is modified by limiting it to the provision of "public health services." The original bill had provided "medical care" as well.

#### *National Research Foundation Bill—S. 1297, S. 1285 and S. 1248:*

The three Senate bills, S. 1297, S. 1285 and S. 1248 authorizing the creation and financial support by the Federal Government of a national research foundation are being considered by the subcommittee of the Committee on Military Affairs. Hearings have been held. Members of the subcommittee are Senators Kilgore, West Virginia, Chairman; Thomas, Utah; Johnson, Colorado; Murray, Montana; Revercomb, West Virginia; Wilson, Iowa.

Dr. Vannevar Bush whose report—"Science, the Endless Frontier" formed a basis of the bill, was a witness. That the Government should stimulate research and assist with appropriations is unanimously agreed, but there is a difference of opinion as to how the Government shall be related to the work. Some recommend that there be created by the President a board of prominent scientists who shall select a director, but he shall not have the



power of veto. Others recommend that the President appoint a director and a board, giving the director full authority. Still others suggest that there shall be two boards, a scientific board and an administrative board, and the director should be over the administrative board. Difficulty in separating fundamental, basic or curiosity scientific research from applied scientific research complicates the problem of administration.

## COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

### County Hospitals in California May Admit Veterans Eligible for U. S. Care

County hospitals may admit veterans with nonservice connected disabilities who are also eligible for care in a Veterans Administration hospital, according to a recent opinion of the Attorney General.

The opinion was prepared for the Kern County Counsel who had inquired concerning the admissibility to the County Hospital of veterans with tuberculosis who are residents of the county but who have available to them adequate medical treatment and hospitalization from the Federal Government.

"The right to receive care at a veterans hospital is not in our opinion a property right," the Attorney General stated. "At least it is not such a right as would prohibit or deny admission to the applicant otherwise qualified for the county hospital."

### California Hospital Advisory Board

Dr. John C. Sharp, medical superintendent of Monterey County Hospital, is chairman of the Hospital Advisory Board, appointed by Governor Earl Warren to assist the State Department of Public Health in the administration of the New Hospital Act.

Serving with Dr. Sharp are: Dr. Charles R. Poitevin, administrator of Long Beach Osteopathic Hospital; Mr. Charles A. Wordell, administrator of San Francisco Children's Hospital; Mr. Paul T. Elliott of Los Angeles Presbyterian Hospital; Mr. A. A. Aita, administrator of San Antonio Community Hospital in Upland.

### Accidental Death Rate Called Low at Los Angeles County Hospital

*Official Testifies County Institution's Record of Fatalities  
Is Below Average*

"Los Angeles County General Hospital has fewer 'accidental' deaths due to improper treatment or the administration of wrong medicine than the average hospital," Dr. Pheobus Berman, director of the medical unit at the institution, on November 7, told an Assembly committee.

"During my 26 years at the hospital, I do recall some accidental deaths, but they occur in every hospital," he said.

#### Public Hearing

His testimony was given before the Assembly interim committee on charitable institutions, which is holding a public hearing in the State Building on conditions at the hospital. The inquiry is the result of the recent "wrong bottle" death of 14-year-old Pauline Estrada, in the Osteopathic Unit of the Los Angeles County General Hospital.

"More than 600,000 patients are treated in General Hospital annually," Dr. Berman pointed out, "and out of that number some, naturally, are dissatisfied with their medical treatment or the services they are given by hospital attendants.

"But the majority of the patients and their families are satisfied—those are the ones from whom you hear no complaints. In fact, we have a large file of letters from ex-patients praising the hospital." . . .—*Los Angeles Times*, November 8.

### Statement of Advisory Committee of Los Angeles General Hospital

In a letter received yesterday by the Board of Supervisors, signed by A. B. Ruddock, chairman of the committee, the following is set forth:

"The General Hospital Advisory Committee has closely followed the circumstances surrounding the recent death of Pauline Estrada in the osteopathic unit of the General Hospital. Members of the committee have inspected the facilities and installations where the regrettable incident occurred and have reviewed the manuals covering medical and nursing procedures in the hospital. The committee has also surveyed the situation with representatives of the staff and the County Medical Association.

"The facts elicited by this investigation serve only to confirm the heretofore held opinion of your committee that this large hospital, with its multiplicity of services, is being well operated. Your committee has full confidence in the administrative officers of the hospital, Mr. Arthur J. Will and Mr. Leroy Bruce. It feels that this unfortunate death cannot be attributed to any failure, or error, on the part of these officers."

Besides Chairman Ruddock other members of the lay committee are: J. C. MacFarland, Maynard McFie, Dr. Robert A. Millikan, Roy E. Naftzger, Mrs. Rollin Brown and Garner A. Beckett.—*Los Angeles Times*, November 3.

### Los Angeles County General Hospital Has a Good Record

Recent statements by Albert B. Ruddock, chairman of the General Hospital Advisory Committee, and by the Los Angeles County Medical Association appear to indicate that much recent criticism of the General Hospital lacks justification. While it is undeniable that in the General Hospital, occasional mistakes have been made both by doctors and nurses which have resulted in death or injury of patients, these errors appear to bear a very small proportion to the number of patients treated.

Mistakes occur in private hospitals and in private practice also. The General Hospital is a very large institution, treating some 2,800 patients daily, and in the course of a year millions of treatments of all sorts are administered. While it is regrettable that any mistakes should occur, it is hardly humanly possible to eliminate all of them. The best of systems will slip up at times, since all humans are fallible.

The hospital is understaffed, both with doctors and with nurses, but this is largely due to conditions beyond the control of the management or anyone else. In the allocation of doctors and nurses the armed forces have had to come first. The opinion of the County Medical Association that the record of the General Hospital is, in view of all factors, excellent and compares favorably with that of private hospitals is entitled to much weight. —Editorial in *Los Angeles Times*, November 10.

### Rates Up at Two San Francisco Hospitals

Two San Francisco hospitals on November 16, boosted rates to meet rising prices and the San Francisco Hospital Conference, representing all but four of the city's hospitals, was "discussing the issue."

Charles J. Malinowski, president of the conference, said

rate boosts have been "under discussion for some time, but the conference has not yet been acted officially."

Two members of the conference, Franklin and St. Lukes hospitals, have acted independently to raise rates.

Superintendent Malinowski, of the French Hospital, said there was "a definite need for increases, in room and board rates."

Increases in food prices have left some hospitals "selling way below cost," he said.

The conference embraces all but Chinese, Sutter, Morton and San Francisco County hospitals.

At Franklin Hospital, rate increases applied to rooms, including board, but did not effect operating room and other fees, it was said.

### Court Holds French Hospital of San Francisco Not Charitable Institution

In a broad ruling affecting hospitals operated by mutual benefit societies, the United States Circuit Court of Appeals here on Dec. 5 ruled that the French Hospital is not a charitable institution and must, therefore, pay Social Security taxes.

The Circuit Court reversed a ruling by Federal District Judge A. F. St. Sure who held that the hospital, operated by La Societe Francaise de Bienfaisance Mutuelle, was not liable for such taxes. Judge St. Sure ordered the United States Collector of Internal Revenue to refund \$35,269 in taxes paid for the years 1936 to 1939.

Because members of the society, who pay a monthly rate to cover medical care, benefit through lower rates, the Circuit Court ruled that the hospital could not be classified as an organization "operated exclusively for charity."

The court's opinion pointed out that more than half of the hospital's 1944 income of \$680,448 came from patients who were not members of the society.—San Francisco *Examiner*, December 6.

### French Hospital of San Francisco Loses U. S. Tax Case

A long-pending dispute as to whether French Hospital was a charitable institution and therefore not obligated to pay social security taxes yesterday was decided by the U. S. Circuit Court of Appeals against the hospital.

An opinion of the Court, written by Judge William E. Orr, held "the hospital is not charitable in any sense" although citing that a large part of the hospital's services went to members of the French Mutual Benefit Society for a monthly assessment of \$1.75.

By the ruling, the hospital is obligated to turn over to the Internal Revenue Collector \$35,269 paid under protest in social security taxes for the years 1936 to 1941. Previously, Federal Judge St. Sure and a deputy revenue collector had ruled in favor of the hospital.

Judge Orr's opinion described the membership hospital service as "low cost" rather than charitable, and cited additionally that non-members paid regular hospital rates.—San Francisco *Chronicle*, December 6.

### Veterans' Hospital Facilities in California

*California Sends Appeal to Truman For 8,000 More Beds*

"Totally inadequate" hospital facilities for disabled World War II veterans in California were described in detail on November 16, by a Senate interim committee which demanded immediate provisions for 3,000 additional beds in Northern California and 5,000 in Southern California.

The demand was in the form of a resolution adopted by the interim committee on veterans' affairs, headed by

State Senator Irwin T. Quinn. It is being forwarded to President Truman, General Omar N. Bradley, director of the Veterans' Administration, the Federal Board of Hospitalization and all members of California's congressional delegation.

The resolution asks that the 8,000 additional hospital beds for veterans in this State be actually divided between general and surgical cases, with adequate provisions for treatment of recurrent tropical diseases, for nervous and mental disorders and for tuberculosis and other respiratory cases.

Hospital needs, the resolution states, were determined from "factual evidence" presented at a hearing held in San Francisco on November 5 and in Los Angeles, November 7. The evidence showed, it continued, that on December 7, 1941, all veterans' hospital facilities were filled to capacity and that since then only 250 beds have been added.

It said California's requirements for rehabilitation of veterans, with 700,000 men inducted from this State and another 350,000 discharged veterans from other states now here, will be more than 33 1/3 per cent above normal.

"A most critical situation now confronts the Veterans' Administration," it declared, "and new facilities and beds must be immediately provided in California to prevent chaos and a breakdown in caring for those who come back from the battlefronts sick, disabled and broken in health."

It called upon the Veterans' Administration to take over Army and Navy hospitals that are being closed, and to allocate some of its \$500,000,000 for new hospitals to California.

### "Hospital Construction and Survey Bill" Endorsed by American Hospital Association

Legislation which would enable the Federal Government to promote the building of hospitals where they are needed as indicated by thorough surveys of state and local needs was introduced early in 1945 into the 79th Congress as the Hospital Construction and Survey Act, Senate Bill S. 191, and is aggressively supported by the American Hospital Association in conjunction with other national health and labor organizations. Several companion bills are also before the House. (The Council of the California Medical Association has at two meetings, approved S. 191.)

These identical bills propose survey and building programs to be administered by state governmental authorities under the general supervision of the Surgeon General of the U. S. Public Health Service, who will be aided by a Federal Advisory Council. S. 191 proposes Federal grants-in-aid for three purposes: to inventory existing hospitals and health centers and to survey the need for additional construction; to recommend construction of public and nonprofit hospitals and health centers that would supplement existing hospitals, clinics and similar services; and thirdly, to aid in the construction of hospitals and health centers in accordance with the needs indicated by such surveys.

The Bill's authorization for appropriation for the first year totals \$750,000,000 with a like amount to be supplied by state and local funds. Hearings before the Senate Committee on Education and Labor were completed in March, and hearings before the House Committee will be opened on November 15. In contrast to the previously established Federal works system which built hospitals without benefit of thorough surveys, S. 191 proposes to build hospitals where they are most necessary and to allot funds according to the relative financial needs of the various states.



## COMMITTEE ON POSTGRADUATE ACTIVITIES

### U. C. Refresher Course in Psychiatry Scheduled

A twelve-weeks refresher course in psychiatry will be offered by the Division of Psychiatry with the help of other divisions of the Medical School of the University of California. The announcement comes from Dr. Karl M. Bowman, director of Langley Porter Clinic on the San Francisco campus, who is in charge of the instruction.

Designed for returning service men who wish to prepare for examinations of the American Board of Psychiatry and Neurology, the course will start on January 7 and will consist of 420 hours of lectures and clinical demonstrations. The enrollment is limited to fifty and only graduate physicians are eligible who have had some experience in psychiatry, but candidates also will be judged on the basis of individual qualifications. Arrangements for the class are being handled by University Extension.

There is a definite shortage of trained psychiatrists, Dr. Bowman says. Only 4,500 psychiatrists are registered in the United States whereas a conservative estimate places the need at more than 10,000.

### Medical Research Fund Gives \$40,000 to U.C.L.A.

A gift of \$40,000 from the Jewish Fund for Medical Research was recently received at the Los Angeles campus of the University of California. This sum is to be devoted to the furtherance of cancer research at that campus, Dr. Robert Gordon Sproul, University president, announced.

The University has already received one-half of the sum and the remainder will be made available in the near future. It will bring to \$50,000 the total amount given to the University by the national fund.

Part of the funds, which were obtained largely through the efforts of David Tratner, Los Angeles merchant, will be used for a special building on the Los Angeles campus. It will be designed to facilitate expansion of a cancer research project already in progress.

Dr. Harry S. Penn, research associate in zoology, who is directing the work, has already pronounced results "encouraging" in this vital investigation of one of the principal mortality causes in the United States today.

A committee of scientists drawn from the Berkeley campus as well as the Los Angeles campus of the University has been appointed by Dr. Sproul. Zoology professor, Dr. Albert W. Bellamy, is in charge of the committee.

### Twelfth Annual Postgraduate Assembly—College of Medical Evangelists

The Twelfth Annual Postgraduate Assembly was held Sunday, December 2, 1945, from nine o'clock in the morning until nine-thirty o'clock in the evening in Paulson Hall, at the White Memorial Hospital, 1819 Michigan Ave., Los Angeles.

All medical men in good standing were invited to register and attend the Assembly. The registration fee was three dollars. Residents, interns, and medical students were guests of the Alumni Association.

#### PROGRAM

9:00 a.m.—"The Examination of Low Back Pain."

Joseph C. Risser, M.D., Clinical Professor of Orthopedics, College of Medical Evangelists School of Medicine, Los Angeles, Calif.

9:30 a.m.—"Ten Million Deafened."

Russell M. Decker, M.D., Assistant Clinical Professor of Surgery (Otolaryngology), University of Southern California School of Medicine, Los Angeles, Calif. (Followed by film—"The Right to Hear.")

10:00 a.m.—"Amebic Hepatitis and Liver Abscess."

A. C. Pattison, M.D., Assistant Professor of Surgery, University of Southern California School of Medicine, Los Angeles, Calif.

10:30 a.m.—"The Importance of Early Diagnosis in Rheumatic Fever."

Louis E. Martin, M.D., Assistant Clinical Professor of Medicine, University of Southern California, School of Medicine, Los Angeles, Calif.

11:15 a.m.—"Remarks on Diagnosis of Brain Tumors."

Carl Rand, M.D., Professor of Neurosurgery, University of Southern California School of Medicine, Los Angeles, Calif.

11:45 a.m.—"The Use of Artificially Radioactivated Elements in Diagnosis and Therapy."

Bertram V. A. Low-Beer, M.D., Assistant Professor of Radiology, University of California School of Medicine, San Francisco, Calif.

12:15 p.m.—"The Diagnosis of Allergic Rhinitis and Asthma."

William C. Deamer, M.D., Associate Professor of Pediatrics, University of California School of Medicine, San Francisco, Calif.

2:00 p.m.—"Management of Carcinoma of the Lower Bowel."

William H. Daniel, M.D., Associate Clinical Professor of Surgery, University of Southern California Medical School, Los Angeles, Calif.

2:30 p.m.—"Interpretation of Intravenous Urograms."

James R. Dillon, M.D., Clinical Professor of Urology, Stanford University School of Medicine, San Francisco, Calif.

3:00 p.m.—"Laboratory Aids in Diagnosis of Endocrine Disorders."

Leo T. Samuels, Ph.D., Head of Department of Biochemistry, University of Utah Medical School, Salt Lake City, Utah.

3:30 p.m.—"Applications for Invisible Plastic Contact Eye Lenses."

Harold F. Whalman, M.D., Clinical Professor of Ophthalmology, College of Medical Evangelists School of Medicine, Los Angeles, Calif.

4:15 p.m.—"Plastic Surgery on the Extremities."

Lt. Comdr. W. John Pangman (MC), USNR, Plastic Surgery Department, U. S. Naval Hospital, Oakland, Calif.

4:45 p.m.—"Office Treatment of Diabetes Mellitus."

Solomon Strouse, M.D., Clinical Professor of Medicine, University of Southern California School of Medicine, Los Angeles, Calif.

5:15 p.m.—"The Changing Picture in Tuberculosis."

Edward Kupka, M.D., La Vina Sanitarium, Altadena, Calif.

7:00 p.m.—"Mental Patients' Attitudes to Their Own Life Histories."

Karl L. Buhler, M.D. (Freiburg), Ph.D., Psychologist at the Veterans' Administration, Los Angeles, Calif.

7:30 p.m.—"Cutaneous Ulcerative Hodgkin's Disease and Tissue Imprints."

Louis H. Winer, M.D., formerly Clinical Associate Professor of Dermatology of University of Minnesota, Minneapolis, Minn.

8:00 p.m.—"The Electron Microscope—Its Significance in Research."

Newton Evans, M.D., Professor of Pathology, College of Medical Evangelists School of Medicine, Los Angeles, Calif.

8:30 p.m.—"The Art, Science, and Business of Medicine."  
W. B. Holden, M.D.

\* \* \*

The College of Medical Evangelists on November 29, presented the first annual Newton Evans Lecture in Bacteriology and Pathology. Speaker: Wesley W. Spink, M.D., Department of Medicine, University of Minnesota Medical School. Subject—Brucellosis: Diagnostic and Therapeutic Considerations.

#### Fifteenth Mid-Winter Convention—Postgraduate Clinical Convention

The Research Study Club of Los Angeles (Eye, Ear, Nose and Throat) has issued its brochure announcing the Fifteenth Annual Mid-Winter Postgraduate Clinical Convention in Ophthalmology and Otolaryngology to be held from January 21 to February 1, inclusive, 1946. There will be the Special Course in "Applied Anatomy and Cadaver Surgery of the Head and Neck," which will be given from February 1 to 5, inclusive. This schedule is so arranged that the Special Cadaver Course cannot interfere with the regular Clinical Convention.

The endeavor is to make the Convention essentially practical; to bring up ideas which the members may take home to utilize in their everyday practice, as well as to stimulate their interest in research studies. The teaching staff will include:

Alan C. Woods, M.D., Professor of Ophthalmology, Johns Hopkins Medical School, and Director, Wilmer Ophthalmologic Institute, Baltimore, Maryland.

Jack S. Guyton, M.D., Associate Professor, Wilmer Ophthalmologic Institute, Baltimore, Maryland.

O. E. Van Alyea, M.D., Associate Professor of Otolaryngology, University of Illinois, Chicago.

Richard Waldapfel, M.D., former Associate Professor, Vienna University, Vienna, Austria. Residence, Grand Junction, Colorado.

Samuel Fomon, M.D., New York City, New York.

Charles E. Kinney, M.D., Lecturer, Graduate School, Western Reserve University, Cleveland, Ohio.

William J. Kerr, M.D., Professor of Medicine, University of California, San Francisco, California.

Herbert M. Evans, M.D., Professor of Biology, University of California, Berkeley, California.

Vern O. Knudsen, Ph.D., Professor of Physics and Dean of Postgraduate School, University of California, Los Angeles, California.

Samuel Salinger, M.D., Clinical Professor of Otolaryngology, Loyola University School of Medicine, Chicago, Illinois.

Meyer Wiener, M.D., Professor of Ophthalmic Surgery, Washington University, Saint Louis, Missouri. Residence, Coronado, California.

Frederick C. Cordes, M.D., Professor of Ophthalmology, University of California, San Francisco, California, and member of the Board of Editors of the American Journal of Ophthalmology, and of the Quarterly Review of Ophthalmology.

Irving B. Lueck, M.S., Rochester, N. Y.

Alvin G. Foord, M.D., Associate Professor of Clinical Pathology, University of Southern California, Los Angeles, California. Residence, Pasadena, California.

Aubrey G. Rawlins, M.D., San Francisco, California.

Samuel A. Crooks, M.D., Professor of Anatomy, College of Medical Evangelists, Loma Linda, California.

William H. Johnston, M.D., Santa Barbara, California.

Simon Jesberg, M.D., Los Angeles, California.

Isaac H. Jones, M.D., Los Angeles, California.

Gilbert Roy Owen, M.D., Los Angeles, California.

J. Raymond Brown, B.S., Los Angeles, California.

For additional information, address Pierre Violé, M.D., 1930 Wilshire Boulevard, Los Angeles, 5.

#### The American Laryngological Rhinological and Otological Society—Western Section

Saturday, January 26, 1946

Elks Club

The Western Section of the American Laryngological,

Rhinological and Otological Society will hold its meeting at the Elks Club in Los Angeles on January 26 and 27, 1946. All members of the profession, whether or not they are members of the Society, are invited to attend.  
2:00 P.M.

1. Introduction of the President, Albert C. Furstenberg, M.D., Ann Arbor, Michigan.

2. "Indications for the Fenestration Operation"—Howard P. House, M.D., Los Angeles, California. Discussion: Robert C. Martin, M.D., San Francisco, California.

3. "Schwannoma (Neurileoma) of the Pharynx with Horner's Syndrome"—Pierre Violé, M.D., Los Angeles, California. Discussion: Emil Tholen, M.D., Los Angeles, California.

4. "Frontal Sinusitis"—J. Mackenzie Brown, M.D., Los Angeles, California. Discussion: O. E. Van Alyea, M.D., Chicago, Illinois.

Sunday, January 27, 1946

Elks Club

9:15 A.M.

5. Business Meeting

10:00 A.M.

6. "Two Interesting Cases of Foreign Body of the Esophagus"—Arthur C. Jones, M.D., Boise, Idaho. Discussion: Simon Jesberg, M.D., Los Angeles, California.

7. "Otolaryngological Problems in Acute Rheumatic Fever"—David Higbee, M.D., San Diego, California. Discussion: Comdr. Joseph B. Stevens, MC, USNR.

8. "Measurement of the Overflow Capacity of the Maxillary Sinus and Its Significance." Ben R. Dygart, M.D., Pasadena, California. Discussion: Samuel Salinger, M.D., Chicago, Illinois.

#### COMMITTEE ON PUBLIC POLICY AND LEGISLATION

##### J.A.M.A. Comments on President Truman's Health Insurance Plan\*

##### THE NATIONAL HEALTH PROGRAM—THE PRESIDENT'S MESSAGE

In the Organization Section of this issue of *The Journal* appears the complete text of the message of President Harry S. Truman to the Congress, delivered on November 19. The text was received as *The Journal* was going to press. The President presents a five point program. The measures proposed by the Hill-Burton bill for increased funds for hospitals and health centers throughout the nation are covered by his first point. The American Medical Association has approved the principles of the Hill-Burton bill subject to safeguards which are in the text reported by the committee which conducted hearings on this measure.

The second recommendation of the President is for expanded maternal and child health services—essentially those proposed by the Pepper bill. It should be apparent that the passing of a nationwide compulsory sickness insurance bill ought to make unnecessary the kind of proposals included under the Pepper Maternal and Child Health measure.

The President urges increased funds for medical education to be given to public and nonprofit institutions for extending medical education and particularly for research in the fields of cancer and mental health. Obviously this proposal is duplicated to some extent by the proposals for the National Science Foundation. This proposal would place the Federal Government definitely in control of

\* For editorial comment, see pages 259-264. Also p. 309.



medical education throughout the United States through its ability to allocate funds to medical educational institutions.

The fourth proposal is for a nationwide system of compulsory sickness insurance to cover every man, woman and child in the United States and to care for the indigent through insurance policies purchased by local agencies for which they would be reimbursed in whole or in part by the Federal Government. The American Medical Association has opposed compulsory sickness insurance consistently for many years. The President reaffirms Senator Wagner's peculiar interpretation of the term socialized medicine by claiming that "this is not socialized medicine." The affirmation will not be convincing to the physicians of the United States who would be compelled to submit to politically controlled medicine should such a measure ever become the law of the nation.

Finally, the President urges compensation of workers for disability due to illness. The House of Delegates of the American Medical Association has approved such proposals in the past.

Fortunately the House of Delegates of the American Medical Association is scheduled for a session to be held in Chicago, December 2-6. The House of Delegates will no doubt at that time state officially the point of view of the American Medical Association on the President's proposals.—*J.A.M.A.*, November 24, 1945.

#### 5-Point Health Plan Offered By President Truman

*Compulsory U. S. Hospital, Disability Insurance, Aid to Mothers Recommended*

President Denies Proposal Is "Socialized Medicine," Says It Will Help Bring Freedom From Want, Boost Production

Washington, Nov. 19.—President Truman today proposed a broad five-point national health program, recommending that Congress adopt a compulsory national health insurance system for the prepayment of medical costs. Stressing that what he was recommending was "not socialized medicine," the President set forth his program in a lengthy message to the House and Senate.

Mr. Truman's basic recommendations for legislative action were:

1. *Federal aid for construction of hospitals, health centers and other facilities where they are needed.*
2. *Increased use of Federal funds to expand coöperative state-Federal public health, maternal and child health service.*
3. *Federal aid to support more adequate professional education and the advancement of research on the cause, prevention and cure of cancer and mental illnesses.*
4. *A compulsory national health insurance system to assure prepayment of medical costs under a plan which would leave patients free to choose their own doctors and hospitals.*
5. *Disability insurance for protection against loss of wages because of sickness and disability.*

#### Increased Production

The President urged Congress to give careful consideration to his program now. The nation's economic productivity, he said, will increase in direct ratio to improvement in the national health.

"Appreciation of modern achievements in medicine and public health has created widespread demand that they be fully applied and universally available," the President said.

"By meeting that demand we shall strengthen the Nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land."

The President, saying that all American citizens should

have ready access to all necessary medical and hospital services, recommended that the basic problem involved be solved by distributing the costs through expansion of the existing compulsory social security insurance system.

#### U. S. Health Fund

Mr. Truman proposed compulsory health insurance which would cover medical, hospital, nursing and laboratory services, and dental care.

His plan would call for establishment of a national health fund which he said would assure adequate support for doctors and hospitals everywhere.

He proposed that the nationwide system be highly decentralized in its administration with local administrative units adapting local services to local needs and conditions.

Subject to national standards, methods and rates of paying doctors and hospitals would be adjusted locally, and these rates would be adjusted upward for qualified specialists.

Repeatedly emphasizing that his plan would not amount to socialized medicine, the President said the people should remain free to choose their own doctors and hospitals. Removal of financial barriers between the patient and the doctor he asserted, "would enlarge the present freedom of choice."

The legal requirement that the people would have to contribute to the program would not, the President emphasized, affect the doctors' freedom to decide what services their patients needed.

At the same time, he added, the people would remain free to obtain and pay for medical services outside the health insurance system just as they are now free to send their children to private instead of tax-supported schools.—*San Francisco News*, November 19.

#### U. S. Chamber of Commerce Takes Stand On Compulsory Insurance

The Chamber of Commerce of the United States has taken a definite stand on compulsory health insurance and has circularized its members with a copy of President Truman's message on the subject.

By a referendum vote of its organization members, the chamber has established a policy on medical and cash sickness benefits which is as follows:

"Employers who have not done so should explore the possibility of providing for their employees some protection against non-industrial or non-occupational disabilities and sickness.

"If, after a reasonable period of time, the private effort of employers to provide protection against non-industrial and non-occupational disabilities and sickness still leaves substantial gaps in coverage, only then should public action be taken.

"If such public action as indicated in Declaration No. 17, this should be at the state and local levels of government rather than at the Federal level.

"If such legislation as indicated in No. 17 is passed, this should permit voluntary group plans to operate as alternatives to government plans.

"Voluntary group effort to provide more adequate medical services for all the people is urged.

"There should be avoidance of a system of socialized medicine, under which all the medical personnel become government employees and the free choice of doctor by the patient and of patient by the doctor is impaired."—*San Francisco Daily Commercial News*, November 30.

#### A.M.A. Policy-Makers Denounce President Truman's Health Plan

Chicago, Dec. 5.—(UP.)—The American Medical Association's policy-making House of Delegates was on

record today with official disapproval of President Truman's proposed national health program.

In the only closed session of the annual meeting, delegates last night denounced the President's tax-supported health insurance proposal as "the first step in a plan for general socialization, not only of the medical profession, but of all professions, industry and labor."

After the meeting, the A.M.A. policy group said in a statement that voluntary prepayment medical plans now in operation in 24 states would achieve all the objects of Mr. Truman's program, as embodied in the Wagner-Murray-Dingell bill, and provide "the highest type of medical service without regimentation."

The statement charged that the Senate measure was "founded on a false assumption that solution of the medical care problem for the American people is the panacea for all their troubles of the needy."

The House of Delegates approved, however, sections of the President's proposal which recommended Federal aid for building health centers and developing a national research foundation.

Sections of the proposal favoring extension of maternal and child care services and compensation for loss of earnings due to sickness were referred back to the public relations and legislation committee for further consideration.

The delegates, representing more than 125,000 American physicians, voted to support the Magnusen bill, which would place a research foundation under a professional, non-governmental scientific board, rather than under one person appointed by the President.

Opposition to the insurance provisions of President Truman's health proposal also was expressed, on the grounds that the program would be "enormously expensive" and would result in increased taxation "for the entire population of the United States."

The delegates also recommended the immediate discharge of all medical officers in the armed services, and approved an offer by the American Red Cross to turn over for use by the civilian population all plasma accumulated from the War and Navy Departments.—*San Francisco News*, December 5.

#### Medical Association Backs Voluntary Prepaid Plans

Chicago, Dec. 5.—(AP.)—The American Medical Association gave the green light today to a program designed to establish a nationwide network of "voluntary" prepayment medical plans, to be sponsored by medical societies.

The Association, through its House of Delegates, took action after branding as "socialized medicine" a proposal by President Truman for a Federal system of sickness insurance.

The Association's board of trustees and its council on medical service and public relations were instructed "to proceed as promptly as possible with the development of a specific national health program, with emphasis upon the nationwide organization of locally administered prepayment medical plans sponsored by the medical societies."

"This is the go-ahead signal we've been awaiting for a long time," said Dr. Edward J. McCormick of Toledo, Ohio, chairman of the council.

#### Voluntary Plans

"The A.M.A. for several years has sponsored extensive studies of existing prepayment plans and has favored the extension of these as much as possible, but we now have an actual directive to promote the establishment of voluntary plans to cover the whole nation."

Declaring that 47 voluntary plans—sponsored by physicians—now are in operation in 24 states and that almost

every other state medical society is in the process of developing plans, McCormick said:

"Up to now the states haven't had much to guide them. But from our studies of existing plans, we will make our first objective the development of a 'skeleton plan' for the guidance of communities now uncovered."

McCormick and other members of his council gave this version of their program:

1. All existing plans and those that may be developed in other areas will maintain local autonomy, but an attempt will be made to coördinate their activities on some common basis so that a subscriber to a plan in Ohio would be able to get medical care in Indiana if he got sick in the latter state.

#### "Blue Cross" Plan

"We hope to get things on such a basis," said Thomas A. Hendricks of Indianapolis, layman executive officer of the council, "that a man can carry a medical service card with him anywhere in the country and get the same service he would in his own home town."

2. Whereas some existing plans are indemnity systems (straight cash at time of sickness) and others are medical service plans (with the plan paying the doctor's bill), Dr. McCormick said the A.M.A. would "very likely" suggest the latter type in new areas.

"Medical care insurance," he said, "might be sold in all probability with hospital coverage programs—such as the Blue Cross."

"We now have enough actual experience from our studies of prepayment plans that we're certain that this type of medical and surgical coverage can be given at less than half the cost that any government plan would entail," McCormick added.—*San Francisco Chronicle*, December 6.

#### U. S. Health Plan Given Congress by President Truman

Washington, Nov. 19.—(INS.)—President Truman sent a special message to Congress today calling for compulsory national health insurance and legislation was promptly introduced in the Senate to carry it out.

The chief executive submitted a five-point program to Congress which would include Federal aid for construction of hospitals.

#### Four Per Cent Exacted

Mr. Truman recommended that health premiums be exacted on a basis of 4 per cent of earnings calculated on the first \$3,600 of income.

"Premiums for present social insurance benefits are calculated on the first \$3,000 a year," he explained. "It might be well to have all such premiums, including those for health, calculated on a somewhat higher amount, such as \$3,600."

The President declared "the poor have more sickness but they get less medical care."

#### Bill Introduced

Immediately after receipt of the President's message Senators Wagner (D., N. Y.) and Murray (D., Mont.) introduced a bill they said would carry out President Truman's recommendations.

The President's program called for:

1. Construction of hospitals, health centers and other facilities with Federal aid.

2. Expansion of public health, maternal and child health services with expansion of coöperative health programs between the federal and state governments with increased Federal funds.

3. Medical education and research under Federal grants.

4. Pre-payment of medical costs through a compulsory national health insurance system.



5. *Protection against loss of wages from sickness and disability with disability insurance to protect America's families by guaranteeing some income when sick or permanently disabled.*

#### No Socialization

The President emphasized that his program does not call for socialized medicine.

"I recommend solving the basic problem by distributing the costs to expansion of our existing compulsory social insurance system," he said. "This is not socialized medicine."

"Everyone should have ready access to all necessary medical, hospital and related services."

The President said that this system should cover hospital, nursing and laboratory services as well as dental care.

#### Choose Own Doctors

He emphasized that patients would remain free to choose their own doctors, physicians would remain free to accept or reject patients, hospitals would continue to manage their own services, voluntary organizations could participate in the insurance system, either to provide services and be paid therefore, or to assist in administration, depending on their functions.

President Truman declared that how much of the total health insurance fund should come from the insurance premiums and how much from general revenues is a matter for Congress to decide.

He said he believes "that all persons who work for a living and their dependents should be covered" under the plan and that this would include farmers, agricultural labor, domestic employees, government employees, and employees of non-profit institutions as well as wage and salary earners, those in business for themselves, and professional persons.

#### Millions Denied Care

The President pointed out that millions of Americans do not have a full opportunity to achieve or enjoy good health or have protection against the economic effects of sickness.

As a further point to back his recommendations, he pointed out that the Selective Service system "had to reject 5,000,000 young men or one-third of those examined," and that an additional 3,000,000 had to be discharged or rehabilitated.

He said that about 1,200 counties, or 40 per cent of the total in the country, with a population of 15,000,000, "have either no local hospital or none that meets even the minimum standards of national professional associations."

#### Needed For Cancer

The President said that a national program of medical research is especially necessary to conquer disease, especially cancer.

"Cancer is among the leading causes of death. It is responsible for over 160,000 recorded deaths a year, and should receive special attention."—San Francisco *Call-Bulletin*, November 19.

#### State Aide Hails Health Plan

Possibility of increased Federal aid for cooperative state-Federal health program was greeted with enthusiasm here today by Dr. W. L. Halverson, State health officer.

"It is hoped that in any expansion there will be provision for local State autonomy in the planning and execution of the program with Federal support limited to setting of standards and approval of plans developed locally to meet local needs," Dr. Halverson said.

The greatest public health need in the United States,

and California in particular, is for more full-time public health officers, Dr. Halverson said, explaining that only 29 of the 58 California counties employ such officials.

#### Present U. S. Grants

More than 1½ million dollars has been appropriated for health work in California for the fiscal year by the Federal Government. From the U. S. Public Health Service has come \$1,009,721 for the venereal disease and tuberculosis program.

The Children's Bureau has supplied \$523,932 to assist local health departments with their maternal and child health services. This includes pre-natal and well-child conferences, immunization programs, diagnostic and medical care for physically handicapped children—particularly those with rheumatic fever, and administration of the emergency maternal and infant care program for wives and children of servicemen in low-pay brackets.

#### Aid Cancer Work

President Truman's request for Federal aid for the advancement of research on the cause, prevention and cure of cancer brought cheer to the American Cancer Institute.

Mrs. Joseph Gould, president of the San Francisco chapter, said the institute, which has been carrying on an intensive education program, would be vitally interested in "any allotment" for cancer research, especially in California, where one out of seven persons die from the disease. The natural death rate attributable to cancer is one out of ten persons, she said.

Meanwhile, the compulsory health insurance program proposed for the nation by President Truman appeared similar to a program advocated for California by Governor Warren.

Bills containing the State program were defeated in the Legislature earlier this year, but Mr. Warren said last week he would continue to work for their enactment in the future.

The President's and Governor Warren's proposals were similar in requiring payment of an additional payroll tax, but allowing patients to choose their own physicians. Mr. Warren asked for a 3 per cent tax divided between employers and employees, while no specific rate was mentioned for the national program.—San Francisco *News*, November 19.

#### A.M.A. Senator Taft Sound Alarm on Health Plan; Stiff Fight Due

Washington, Nov. 20.—President Truman's far-reaching health insurance program today faced a hard fight in Congress.

Even backers of the three-billion-dollar-a-year proposal conceded that strong opposition lies ahead. Similar proposals introduced a year ago died in committee.

Despite Mr. Truman's repeated statement that his program did not mean "socialized medicine," the *Journal of the American Medical Association* charged editorially that the proposal would lead to "politically controlled medicine."

Senator Robert A. Taft (R., O.) also disputed Mr. Truman's denial that the program involved socialized medicine. President William Green of the A.F.L., however, telegraphed Mr. Truman congratulations on his "forward-looking" proposal which, Mr. Green said, "meets the most urgent human needs of our nation and merits universal support."

The President's plan would guarantee proper medical care for every American, financed through increasing Social Security taxes and, later, by taking monies from general tax collections.

One suggestion is to increase the Social Security tax

for the employer and the employee an additional 1½ per cent each on annual salaries up to \$3600.

Senator James E. Murray (D., Mont.), one author of the bill, plans to start the month-long hearings within 10 days.—*San Francisco News*, November 20.

#### C.M.A. Favors Truman Health Program, But—

The California Medical Association today declared it favored President Truman's health insurance program, but asserted the method selected to achieve the objective would bring "regimentation of both patient and physician."

"The Association heartily approves of the President objective—to assure prepayment of medical costs under a plan which would leave patients free to choose their own doctors," said John Hunton, executive secretary.

"However, we just as vigorously disapprove of the method selected to achieve this objective—a compulsory national health insurance system."—*San Francisco News*, November 20.

#### Early Attention But Deferred Again

Washington, Nov. 20.—(AP.)—President Truman's request for a broad health and medical program received assurances today of early congressional attention but deferred action. Its points also met with both approval and disapproval of the American Medical Association.

Representative Priest (D., Tenn.), chairman of the House Interstate Health Subcommittee promised hearings soon, but he declined to say just when they would start or how long they might last.

Senator Wagner (D., N. Y.), who with Representative Dingell (D., Mich.), introduced a bill to carry out the President's recommendations, predicted Senate Labor Committee action within two months.

Otherwise, congressional reaction to the message read by a House clerk to about a score of members was indefinite. Most of the lawmakers told reporters they wanted to know more about it, particularly if it approached what some called "*socialized medicine*."—*San Francisco Chronicle*, November 21.

#### The President's Health Program

President Truman's message to Congress on a national health program presents the usual array of arguments used by the proponents of compulsory health insurance. There is the familiar insistence that it doesn't mean socialized medicine and the conventional gesture toward permitting voluntary coöperative organizations to participate "if they can contribute to the efficiency and economy of the system."

The presentation of broad generalities as to the need for more and better health and medical facilities is one thing; the translation of them into law short of socialization is another. California's recent experience with the various compulsory health insurance proposals exemplified this.

Good health, which does not necessarily mean perfect health, is man's most precious asset. Whether through private or public systems offering prepaid hospital and medical care or sickness insurance, the objective sought presumably is the same. The province of the state in the realm of public health has long been accepted. A basic question posed in compulsory health insurance is just how far the state should go in concerning itself with individual needs.

At first glance one would think that doctors who frequently find difficulty in getting their pay would welcome relief on this score. But many doctors nevertheless conscientiously oppose compulsory systems which they see as leading toward regimentation of their profession and the

leveling off of the quality of service as the spur to individual incentive is dulled.

They may be wrong but thus far the record of American medicine when set against that of countries which have compulsory systems has not suffered by comparison.

There are so many different angles to the entire problem that generalities tend to oversimplify a highly complex problem. It is trite to say that no amount of money alone can buy good health. But it is true. The members of the medical profession themselves will be among the first to admit that they have not the answers to many of the problems involved in the mental and physical ailments which afflict mankind.

President Truman mentioned the Selective Service examination record but he did not analyze it from the standpoint of (1) either the lack of opportunity for proper care, or (2) whether medical care alone would have materially changed the picture. A recent report on 4,154,000 4-F's showed that 701,700 were disqualified for mental disease and another 582,100 for mental deficiency including those with low I.Q.'s and the illiterates. Those labeled "manifestly disqualified" included men without an arm, blind or who had other obvious defects. This left under the classification of "physical defects" 2,426,500.

Of this latter classification, the largest group comprised men rejected for muscular-skeletal causes. They numbered over 300,000, a third of whom were suffering from the results of injuries such as missing fingers, badly set bones and stiffening of the joints. Curvature of the spine, clubfeet, deformities of the toes, pigeon chests and the aftereffects of osteomyelitis also were included in this classification.

The second largest group were men suffering from syphilis. They numbered between 250,000 and 300,000. New drugs apparently have speeded up the cure of syphilis but doctors will tell you that the greatest difficulty in effecting cures in this (as in other diseases) is getting the patient's coöperation in sticking to the prescribed routine until cured.

Next to the syphilitic group came men with heart and circulatory ailments. Between 200,000 and 250,000 were rejected respectively for hernia, bad eyes and neurological ailments which covered a large number of epileptics. Bad ears caused the rejection of between 150,000 and 200,000 while tuberculosis was found in upward of 50,000. Under 50,000 each were groups rejected for overweight and underweight, bad feet, kidney and urinary ailments, varicose veins, bad teeth, bad skin, nose and throat trouble, gonorrhea and hemorrhoids.

The recital of the causes of these rejections at least tends to accentuate the complexity of the problems involved in a health program. Paradoxically many of these 4-F's will be active and alive after their more healthy brethren have passed away.

The Federal Government through public health measures, through aiding in the provision of needed hospitals and medical centers and in other broad ways can undoubtedly do much toward improving health standards. To the extent that it helps voluntary systems of prepaid hospital and medical care, it will be promoting a desirable movement which from all indications can be more fully exploited than it has been.

But Congress will be well advised to consider carefully the full implication and impact of a system of taxation and the disbursement of billions of dollars under compulsory health insurance.—Editorial in *Los Angeles Times*, November 21.

#### President Truman's "Must" Measures Gather Moss in Congress

Washington, Nov. 20.—President Truman's "must"



legislation is getting musty in congressional committees.

Although the President brought Congress back from a recess Sept. 15, his postwar reconversion program has made little progress.

Congress has passed a tax bill (not exactly to Administration specifications) and that's about all it has done legislatively. It did pass a bill to recapture excessive war appropriations. . . .

Most of the "must" legislation sought by President Truman was outlined in his message which he read when he called Congress into session after the summer recess.

From September 15 to October 26 the President sent 65 messages to Congress. Many of them dealt in detail with his legislative program. But after Thanksgiving Congressmen will be looking forward to Christmas holidays and it is likely to be well into 1946 before the Truman program takes shape—if then.—Daniel M. Kidney, in *San Francisco News*, November 20.

### Health Insurance—President Truman's Proposals

We have long supported the efforts to establish a health insurance system in California. We believe a medical care program should be operated by the individual states and not by the Federal Government. We have a profound distrust of remote control by a vast Washington bureaucracy of a concern touching so intimately the lives of the citizens.

Our lack of confidence in the plan President Truman proposes is not made less by the language in which he describes it. On May 28 of this year we suggested to the California Legislature that it take careful note of Senator Wagner's then proposal of a vast Federal health insurance operation as a threat hanging over the State if it failed to install its own program. We then said that if there were no other defects immediately apparent in the Wagner scheme the language in which the New York Senator urged it would alone arouse deep suspicion.

We now find it is Wagner's sleeping plan which is revived to be brought before Congress at this moment and that in urging it President Truman has only echoed what Wagner said last spring.

The President repeats Wagner in asserting that this plan is not "socialized medicine." "Socialized medicine," he said, "means that all the doctors work for the Government." That is only Truman's, or rather, Wagner's definition. There is more than one way of tying a knot. Wagner said it would not mean "regimentation." Any compulsory rule laid on the citizens is regimentation. We could have regimentation in a State system, too; we recognize that, but it is the unfrankness of these declarations that rouse us here. To us these assurances are nothing more than attempts to soothe persons who do not like the terms "regimentation" and "socialized medicine." They should not fool anyone who can put two and two together.

Similarly unfrank seems the President's assertion that the system must be "highly decentralized in administration" though the fund "should be built up nationally." These two elements are completely incompatible. Whoever holds the purse runs the show and from the place where the money is held. Nothing run by Washington is ever decentralized. OPA is a good example; it is supposed to be decentralized with district and local administrators, but anyone who has had dealings with it knows every new question has to be referred to Washington. In other words, you can't decentralize centralization.

We agree that a health insurance program should be decentralized. In our opinion the best and only chance of a degree of decentralization lies in state-run health insurance systems. Who wants to wait on Washington to de-

cide whether his particular kind of case is in the rule book?

We assume it is only to catch the doctors that the President spreads the molasses of "more money for all of them." We are unable to calculate how this could be on the basis of the President's statement that the requisite 4 per cent tax to raise the fund is only about what Americans now spend for sickness care.

We do not want another national bureaucracy to create another huge pressure group in Government.—Editorial in *San Francisco Chronicle*, November 21.

### Assembly Interim Committee on Sickness Insurance

Representatives of the San Francisco Municipal Health and Hospitalization Insurance System, the Blue Cross and the California Physicians' Service were invited to present their views on health insurance before a session of the Assembly Interim committee on health care, held in San Francisco, on November 9 and 10.

Assemblyman Ernest Geddes, chairman of the committee, announced scheduling of the San Francisco meeting.

The committee was created by the Assembly as a result of the movement started by Governor Warren for establishment of a system of compulsory health insurance in California.

Interim Committee must submit a report before July, 1946.

### The 1945 Wagner-Murray-Dingell Bill

*A Bold Plan: Its Provisions Are Controversial—  
Its Implications Are Grave*

*Importance.*—The importance of the 1945 Wagner-Murray-Dingell Bill lies not so much in the likelihood of adoption in its present form as in the fact that it demonstrates the determination of its advocates to secure action. This in spite of the lack of consideration accorded the original measure.

*Compared to the Original Measure*, introduced in the previous Congress but never considered, the new measure differs mainly by reason of the effort made, through various devices, to appease certain opponents and to draw in greater and more enthusiastic support.

Most important of these devices is the *reduction of the "contribution" rates* proposed as compared to those proposed originally. Labor support had been tempered by expressions of doubt concerning the 6 per cent payroll deductions first advocated. It is to be presumed that labor will find the 4 per cent rate now proposed much more acceptable. Washington reporters, however, have made allusions to the possibility that Chairman Altmeyer, of the Society Security Board, suspects that the bill is financially unsound. Apparently the reduction in contribution rates is wholly accounted for by adoption of a pay-as-you-go principle with respect to Old-Age and Survivors' Insurance financing.

Congress now has before it the Hill-Burton bill providing for Federal aid in *hospital construction and maintenance*. In view of the support accorded this measure, the inclusion of a more or less similar proposal, outlined in great detail, in the new Wagner bill has been widely commented upon. Most commentators agree that Senator Wagner hopes, in this way, to draw additional support to his measure.

The new Wagner bill includes an attempt to decentralize the administrative setup proposed to carry out its medical care provisions by providing for localized control. In introducing the measure to the Senate, Senator Wagner called attention to this as evidence of the lack

of any purpose or desire to "socialize" medicine. Editorial comment in leading medical journals does not indicate any hope of success for this appeasement effort.

*Cost.*—Neither the sponsors nor any official agency have published estimates of the cost of the proposed program of compulsory social security. This omission has been noted by numerous editorial writers through the country.

Private sources—such as Research Council for Economic Security—have estimated the ultimate cost at \$15 billion upwards, annually. On the basis of an immediate cost of \$10 billion a year (much of it for health insurance) and an ultimate cost of \$15 billion a year, the program proposed would absorb 8 to 12 per cent of a national income of \$120 billion annually. This would mean from 12 to 17 per cent of payroll.

Foreign experience indicates that no sound economy can bear such a cost and still maintain the momentum of private incentive and enterprise.

*Costs.*—The above estimates may be too conservative. For example, the spring (1945) issue of Quarterly Journal of Economics, contained a detailed, actuarial study of "Estimated Cost of Old-Age and Survivors' Insurance," by Professor I. J. Sollenberger, University of Oklahoma. So far as is known, it is the first attempt to establish the ultimate cost of the system as it might be expanded by adoption of the Wagner bill. The study indicates that this part of the program alone might involve an ultimate cost of not far from 10 per cent of payrolls, and thus, in itself, create too great a burden upon private enterprise, without considering the cost of health insurance, unemployment compensation, etc.

*Consequences.*—Too costly a program may have grave and unexpected results. High taxes handicap enterprise, discourage expansion, scare off investments and undermine job stability. As private enterprise retreats, government activity is likely to expand in fields of production, distribution, finance, transportation, public utilities and general economic planning.

The proposed program attempts to redistribute income and thus support consumer buying. But if, by discouraging enterprise, it restricts production, will there be enough goods to distribute? In other words, will standards of living in this country tend to decline?

*Snowball Tendencies.*—The sanguine attitude of advocates of expansion of compulsory social security toward costs is not justified by experience either at home or abroad. In foreign countries, where the experience is much longer, it has never been possible for politicians to resist demands for continuous expansion and costs have mounted steadily through the years. Domestic experience while much shorter, follows the same pattern. As one author puts it, one is reminded of a snowball rolling down hill and gathering both size and velocity on its journey.

*Enterprise Ignored.*—The advocates of the program placidly ignore the accomplishments of and the opportunities offered by private enterprise. Despite the outstanding accomplishments of private enterprise in recent years, they do not admit the possibility that enterprise is any longer dynamic.

The extensive and rapidly increasing structure of protection built up by voluntary insurance institutions and through other types of thrift programs is likewise ignored. Indeed, much of the coverage proposed by the Wagner bill would only replace existing protection.—*Insurance Economics Society of America Bulletin.*

#### President Truman's Health Plan Criticized

Kansas City, Nov. 26.—(AP.)—Dr. Harold T. Low, Pueblo, Colo., today described President Truman's proposal for medical care as "an utopian dream and if tried will be a failure like the prohibition law."

Dr. Low is president of the Association of American Physicians and Surgeons.—*San Francisco Chronicle*, November 27.

#### Public Health Plans Backed

##### State Group Favors Medical Care Insurance Program

Sacramento, Nov. 5.—(AP.)—The State Reconstruction and Reemployment Commission voted, 5 to 4, today to approve the recommendation of a citizens' advisory committee urging early enactment of a State-wide program of public health and medical care insurance.

Voting for health insurance were Percy Keckendorf, State director of professional and vocational standards; Dr. Robert Gordon Sproul, president of the University of California; Paul Scharrenberg, director of industrial relations; William T. Sweigert, executive secretary to Governor Warren. (Query. Was the 5th vote recorded in the majority list of 5, that of the late Walter F. Dexter, California Superintendent of Public Instruction, whom death antedated the meeting referred to by several weeks?)

Voting in favor of taking no action at this time on the health insurance recommendation were:

James S. Dean, State finance director; Charles H. Purcell, director of public works; Warren Hannum, director of natural resources, and A. A. Brock, director of agriculture.—*San Francisco Examiner*, November 6.

#### Doctors Rap State Group's Health Stand

Through Dr. John Cline, chairman of its executive committee, the California Medical Association (C.M.A.) on November 6, took public exception to the action of the State reconstruction and reemployment commission in urging creation of a compulsory health insurance system.

Declaring that "the commission seems more interested in political reconversion than in further industrial reconversion and reemployment," Doctor Cline added:

#### Hints Politics

"When there are so many pressing reconversion problems which come within the commission's scope, and which are far from solved, it is unfortunate that the commission should go beyond the purview of the act which created it to dabble in as controversial a political issue as State medicine."

Health insurance became a political issue last January, when Governor Earl Warren asked the Legislature to set up a State-operated system. Several bills, including two sponsored directly by the Administration, died in unfriendly legislative committees and no health insurance program reached the floor of either house for a vote.

The reconstruction and reemployment commission on Monday voted 5 to 4 to approve the recommendation of a citizens' advisory committee urging early action to establish health insurance. Doctor Cline, on behalf of C.M.A., branded this act as "presumptuous," and asserted that the commission has permitted itself to become "a propaganda agency and a pleader for special causes."

Meanwhile, two special interim committees of the legislature are making a study of the entire question of voluntary versus compulsory health insurance and prepaid medical care.—*San Francisco Examiner*, November 7.

#### Governor Warren Still Advocates Health Insurance, Desires Program

Governor Earl Warren has not changed his opinion in the slightest about prepaid state health insurance, despite his defeat in advocating it at the 1945 legislative session, and he is hopeful the Senate interim investigating committee will bring the importance of this issue even more forcefully to public attention.

This was made abundantly clear in a brief statement by Warren just before he left Sacramento last night for a series of governmental conferences in the Middle West.

The special senate committee on payment of medical and hospital care, charged with making a complete survey of the public health insurance question, will meet in the capitol tomorrow.

#### Glad Committee Active

"I am happy that the senate committee is becoming active," commented Governor Warren, "and I trust it will make a thorough study of the situation and advise both the Legislature and the public of the necessity for making a direct attack on this major health problem of our people."

"The health of the people is the most fundamental problem in American life today. Any fair and impartial study of the problem by our Legislature should bring us closer to a solution."



Supporters of the two prepaid health insurance measures which were presented unsuccessfully at the regular legislative session—one by Republican Governor Warren, the other by the Congress of Industrial Organizations—are inclined to figure a majority of the senate committee as possibly favorable to such legislation. The Warren and CIO bills were stymied in the assembly and did not come to a senate vote.

#### Salsman Heads Group

The senate investigating committee is headed by Senator Byrl R. Salsman of Santa Clara County, author of a Warren proposal similar to that defeated in the lower house. Serving with him is Senator John F. Shelley of San Francisco, accounted an advocate of health insurance. The other three committeemen are Senators Chris N. Jespersen, San Luis Obispo County; Louis G. Sutton, Colusa County, and Arthur H. Breed, Jr., Alameda County.

The assembly also has a health care investigating committee (of seven members) on which Speaker Charles W. Lyon, opposed to the Warren proposal, has appointed a majority who voted to keep both the bills of the administration and the CIO bottled up in committee last Spring.

Senator Salsman announced a part of tomorrow's session of the upper house study group will be devoted to considering qualifications of persons suggested for the post of investigation research expert. He said the committee intends to employ "an impartial and unbiased expert to survey the problem of medical care in California and advise on questions of need and cost."

#### Program Still Alive

Developments of the last fortnight show plainly enough that the prepaid health insurance program and the controversies which grew out of its presentation to the last Legislature are far from dead.

The State reconstruction and reemployment commission, for instance, voted at its last meeting to approve recommendations by a citizen advisory committee on social and industrial welfare in favor of early enactment of a health insurance law.

Immediately the California Medical Association high command swung into action with a vigorous denunciation of the RRC.

The recommendation which the RRC endorsed simply read as follows:

"That the State Reconstruction and Reemployment Commission give every possible assistance to the interim committee of senate and assembly in order that a sound program of health insurance and medical care may be enacted at the earliest possible date."

#### Politics Charged

This drew a quick charge from Dr. John Cline, chairman of the executive committee of the California Medical Association, that the RRC in apparently "more interested in political reconversion than in furthering industrial reconversion and reemployment."

Of course, six of the nine RRC members who voted to endorse health insurance are members of Governor Warren's cabinet, so it was not exactly surprising that this agency should agree with Warren's advocacy of extending social security in the field of health and medical care.

Dr. Cline, however, had this to say:

"When there are so many pressing reconversion problems which come within the commission's scope, and which are far from being solved, it is unfortunate that the commission should go beyond the purview of the act which created it to dabble in as controversial a political issue as State medicine."

#### Merry Go Round Begins

Then the political merry go round started off full tear on health insurance. The assembly investigating committee called a meeting. Then the senate committee called one.

Next came predictions from a source decidedly friendly to the California Medical Association that a drive to abolish the reconstruction and reemployment commission will be made by "indignant lawmakers" when Governor Warren calls his expected special legislative session.

This forecast was circulated by Clem Whitaker, the San Francisco publicity agent and campaign manager who opposed Warren's health insurance bill in the Legislature. He reported people are sore at the RRC, among other things, because it has "gone beyond the scope of activities laid down for it by the legislature and has sought to become a policy making board and to influence legislation . . . giving a favorable recommendation to such red hot legislative proposals as compulsory health insurance . . ."

#### Allied With C.M.A.

Capitol quarters well disposed toward the RRC pointed

out Whitaker was engaged in the fight of the C.M.A. and affiliated forces to defeat compulsory health insurance this last Spring.

The Warrenites emphasized that Whitaker now is one of the chief boosters of Earl Lee Kelly as a potential Republican candidate for Governor against Warren.

And Kelly, in turn, they added, is damning Warren for proposing health insurance in the first place.—Herbert L. Phillips in *Sacramento Bee*, November 14.

#### U. S. Health Aid Planned

Washington, Oct. 19.—A revamped bill for Federal aid to hospital and health center construction is ready today for approval by the Senate education and labor committee.

It will provide for Federal grants amounting to 75 million dollars a year for five years. In addition, it appropriates five million dollars for a survey of the nation's hospital and health center needs.

Originally introduced by Senators Hill (D., Ala.), and Burton (R., O.), it was rewritten in a subcommittee of which Senator Hill was chairman.

Under the revised measure a formula is provided for distribution of the funds on a population and per capita wealth basis. It will give 15 of the poorest states, mostly in the South, 47.8 per cent of the funds; 16 middle bracket states 18 per cent and 18 richest states, 31 per cent. Territories would get 3.2 per cent.

The original plan for matching funds for public and non-profit hospitals on a 50-50 basis was abandoned. Instead the Federal contribution will range from 33 per cent for the richest states to 75 per cent for the poorest.

No state can obtain a grant of less than \$10,000 a year, but it may borrow Federal funds for matching purposes.—*San Francisco News*, October 19.

#### Doctors Are Against "Political Medicine"

Los Angeles (UP).—Government sponsored health programs were denounced today by Dr. L. A. Alesen of the California Medical Association as "political medicine."

Alesen, addressing delegates to the California Farm Bureau Federation regional convention, attacked both large and small medical service plans and described the American system of individual medical attention as the best in the world.

Dr. Clifford H. Loos told delegates the health of Californians must not be endangered by "chain store" medical methods.

"I firmly believe in group medicine, but it must be in localities, not on a national or even state scale," he said.—*Merced Sun-Star*, October 26.

#### Warren Firm On Health Plan

Sacramento, Nov. 14.—Governor Warren indicated today he has not given up hope of enactment of a State health insurance program in California.

Before leaving on an Eastern trip, the Governor was asked to comment on the opening of hearings on November 15, on health insurance plans by a Senate interim committee. He said he had not changed his mind since advocating an insurance bill at the Legislative session earlier this year.

Senator Byrl Salsman (R., Palo Alto), chairman, had asked Governor Warren to appear before the committee, but the Governor said he was prevented by earlier plans to attend a conference of Governors' meetings in Chicago and Cheyenne, Wyo.—*San Francisco News*, November 14.

**Francis Thompson (1859-1907).**—Thompson called his body "a Pandora's box, containing all the ills that afflicted humanity." Possibly, his "long feverish illness," at the age of 20, was an early sign of the tuberculosis from which he died. At this time also, he became acquainted with opium as a result of his mother's gift of "Confessions of an Opium Eater." Disease, opium and poverty reduced him to a life on the London streets, fetching cabs and selling matches. The moral tone of his literary work remained high.—Warner's *Calendar of Medical History*.

For they lived long enough, that have lived well enough.

—Thomas Wilson, *Arte of Rhetorique*, 83. (1560).

## COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

### Typhus Fever—Los Angeles Report

George M. Uhl, M.D., Health Officer of City of Los Angeles, recently reported:

There have been 19 cases of typhus fever in the city of Los Angeles during the first 10 months of 1945, in contrast to 8 during the same period of 1944, and an average of 10 cases annually for the past five years. Ten of the 19 cases were reported during the months of September and October. Seven persons were bitten by rats in October.

There are two types of typhus fever: 1. *Epidemic*, which is transmitted from one human being to another by the bite of the body louse (clothes louse). This type is common in Europe and has a high mortality; and 2. *Endemic*, which is transmitted to human beings from the rat by the bite of the rat flea (*xenopsylla cheopis*). This type occurs in Southern California and has a low mortality.

In order to control the endemic type it is necessary to control rats. However, the Los Angeles City Health Department does not operate a rat exterminating service except for public areas. The Rodent Control Division of the Health Department keeps an index of the rat population, examines rats for the presence of diseases transmissible to human beings, and cooperates with the U. S. Public Health Service and the State Health Department in administering and enforcing laws which require property owners to maintain their premises in a rat-free condition. It would be impossible for the personnel of this division to make any substantial dent in the rat population of the city merely by extermination.

The Los Angeles City ordinance requires owners of buildings to:

1. Ratproof or rat-stop all buildings by screening foundation vents, closing openings, etc.;
2. Store in ratproof containers all material (food, animal feed, garbage, etc.) that may afford food for rats;
3. Destroy rat harbors by eliminating accumulations of rubbish, junk, etc.;
4. Diligently exterminate rats.

All of these methods of rat control must be carried out by all property owners to significantly control the rat population. The Los Angeles City Health Department calls on all home and building owners to cooperate in eliminating this menace.

### Hooper Foundation of U.C. Studies Encephalitis

The reservoir of infection of encephalitis, which exists in many west coast areas, has been found to be birds, both wild and domestic, according to Dr. W. H. Hammon, associate professor of epidemiology, and Dr. W. C. Reeves, research associate, at the Hooper Foundation for Medical Research on the San Francisco campus of the University of California. The infection by the virus causes no disease in the birds but produces a serious illness in both horses and man.

Transmission of the virus is by means of the bite of a mosquito which first has fed on the infected birds. Dr. Hammon says. Thousands of other biting pests, including ticks, mites, fleas, lice, flies, kissing bugs, and bed bugs, have been collected by staff members of the Foundation and tested as carriers, but only mosquitoes have been found to be infected. A study of the feeding habits of the principal mosquito vectors shows that they prefer to feed on birds, followed in order of preference by cows, horses, and man. Only 2 per cent or less feed on man, the research shows.

Horse encephalitis is common in most west coast areas,

but can be controlled by vaccination. In man the disease has caused sharp explosive epidemics but usually is confined to endemic areas in the hot valleys. The incidence in any area rarely exceeds about one in a thousand of the population, so large-scale vaccination of humans is not recommended. Cases occur in rural areas, small towns, and in the suburb areas of large cities where chickens are kept in back yards. Mosquito control in these areas is recommended as the first line of defense.

### Kenny Poliomyelitis Drive

#### *Half of Funds Stay in State*

One-half of the funds raised in each state during the Sister Elizabeth Kenny appeal starting November 22 will remain in that state to aid the local fight against infantile paralysis, it was announced recently.

Objectives of the campaign are to build Kenny hospital wings and clinics, to provide Kenny treatment for infantile paralysis patients, and to provide scholarships for graduate nurses to become Kenny technicians.

"If we are to win the battle against infantile paralysis there must be funds for research and funds for the treatment of those who fall victim to its ravages," E. G. Hubbard, Northern California campaign chairman, said.

"It is our hope that the Sister Kenny method of treating infantile paralysis can be brought into every community, that a Kenny trained technician can be assigned to hospitals in every hamlet so that when infantile paralysis strikes it will find opposition."

### Fourteen Signs of Illness in Children

A recent bulletin of the Health Advisory Council of the Chamber of Commerce of the United States, Washington, reminded mothers of 14 signs of illness in children to which particular attention should be paid.

The 14 signs, which may indicate any one of a number of serious illnesses requiring the immediate attention of a doctor, have been listed by the Children's Bureau of the U. S. Department of Labor. They are:

- "Fever.—Flushed cheeks and hot dry skin.
- "Irritability.—Fussing and whining by a child who usually plays and is happy.
- "Drowsiness.—Wanting to sleep more than usual, especially at a time when he usually plays.
- "Loss of appetite.—Refusal of foods by a child who usually eats well.
- "Vomiting.—May be after eating or taking liquid or may not. Notice whether vomiting is mild or forceful (projectile).
- "Diarrhea.—A sudden increase in the number of stools, especially if they are loose and watery. This may be an early sign of any infection or of a disease of the bowels. If pus, blood, or a large amount of mucus is in the stools, the doctor should be called.
- "Runny nose.—A running nose in a child may be the beginning of a cold or of some other communicable disease, such as measles, influenza, or whooping cough.
- "Cough.—A cough in a child is more likely to be a sign of illness than in a grown person.
- "Sore throat.—May be associated with a cold or may be the beginning of another communicable disease, such as diphtheria or scarlet fever.
- "Hoarseness.—A huskiness in the voice, if accompanied by fever, may be the first sign of diphtheria. A doctor should be called at once.
- "Pain.—A child who complains of persistent pain in any part of the body should be seen by a doctor. Earache, severe headache, or pains in the stomach, abdomen, chest, or joints may indicate serious disease, infection, or injury.
- "Convulsions.—Convulsions, spasms, 'fits,' or twitching of the face or arms or legs may be an early sign of some serious disease in the child.
- "Stiffness of the neck or back.—May be associated with disease or irritation of the nervous system.
- "Rash.—A breaking out on the child's skin."

A child with any of these 14 signs of illness should be put to bed, and if his temperature is over 101 degrees, a doctor should be called.



# MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

## NEWS

### Coming Meetings†

**California Medical Association.** Session will convene in Los Angeles. Headquarters, Hotel Biltmore, 5th and Olive Sts. Dates of meetings: Tuesday, May 7-Friday, May 10, 1946.

**American Medical Association.** Next annual session will be held in San Francisco, Monday-Friday, July 1-5, 1946.

### The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in *CALIFORNIA AND WESTERN MEDICINE* for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576. Also, August, 1945, *CALIFORNIA AND WESTERN MEDICINE*, pp. 61-62.) On p. 61 (*C.M.A.*) and p. 62 (*A.M.A.*)

### Medical Broadcasts\*

**The Los Angeles County Medical Association:**

In December, KFAC will present broadcasts on Saturdays at 10:15 a.m.: December 1, 8, 15, 22 and 29.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

For radio broadcasts of "Doctors at War" by the American Medical Association, see *J.A.M.A.*

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week. In *CALIFORNIA AND WESTERN MEDICINE*, some rosters appear in every second or third issue.

\* County societies giving medical broadcasts are requested to send information as soon as arranged.

### Pharmacological Items of Potential Interest to Clinicians\*:

1. *Symposia:* Excellent one on cardiac output by A. F. Cournand, W. F. Hamilton, I. Starr, J. L. Nickerson, J. McMichael and D. W. Richards (*Fed. Proc.*, 4:183-220, 1945). Then go on to W. F. Hamilton & Co.'s neat studies on propagation velocity of arterial pulse wave, cardiac ejection curves, and ballistocardiographic forces (*Am. J. Physiol.*, 144:521-570, 1945). Note papers on intervertebral disc and lumbago by E. J. Crisp, B. H. Burns, R. H. Young and J. Cyriax (*Lancet*, 249:422-429, October 6, 1945). Important series on physics in medicine by W. V. Mayneord, H. Hurst, G. E. Donovan, D. S. Evans, K. Mendelsohn and A. H. S. Holbourn (*Brit. Med. Bull.*, 3:129-151, 1945), including interesting historical notes. Note potential competition from R. Geigy & Co. on recent researches on malaria in Switzerland (*Acta Tropica*, 2:1-159, 1945).

2. *Ethics:* P. Romanell takes "Ethicogenesis" for a technical hayride (*Sci. Month.*, 61:293, 1945; for other cracks see p. 329). O. L. Reiser looks to the *Promise of Scientific Humanism* (Creative Age Press, N. Y., 382 pp., \$4), and proposes an institute of scientific humanism (*Philos. Sci.*, 12:45, 1945). Meanwhile G. Sarton publishes *Isis*, and too few help him. W. A. R. Leys writes on *Ethics and Social Policy* (Prentice-Hall, N. Y., 522 pp., \$3.50). A. Edel discusses key concepts in ethical theory (*Philos. Rev.*, 12:260, 1945). A. Robertson offers *Morals in World History* (C. A. Watts, London, 1945, 126 pp., \$2.50). C. L. Stevenson joins *Ethics and Language* (Yale, New Haven, 1945, 350 pp., \$6). A. M. Schwitalla S. J. undertakes to edit *The Linacre Quarterly*, a journal of the philosophy and ethics-of medical practice from the orthodox standpoint. D. M. Emmet describes *Nature of Metaphysical Thinking* (MacMillan, 1945, 238 pp., \$2.50), which contains statements, if you're interested, about the real which transcends experience! Vale to B. Malinowski who closes career with *Dynamics of Culture Change* (Yale, New Haven, 1945), and *A Scientific Theory of Culture* (University No. Carolina, Chapel Hill, 1945, 228 pp., \$4). A. G. Ramsperger notes misplaced modesty of scientists (*Antioch Review*, Winter, 1945, p. 581). A. Dresden's *Mathematics as an Inter-cultural Bridge* remains unpublished from 6th conference on Science, Philosophy and Religion, and it's pertinent. Lots of physicists seem willing to accept responsibilities of implications of current scientific work; why not a series of seminars, conferences and congresses with biologists, physicians, sociologists, philosophers and policy leaders? Note A. R. Zhebrak's comment (*Science*, 102:357, October 5, 1945). British scientists propose international science cooperative service (*Nature*, 156:401, October 6, 1945).

3. *Antibiotics:* M. I. Smith and W. T. McClosky find streptomycin has chemotherapeutic index ten times that of promin in experimental TB (*Pub. Health Rep.*, 60:1129, September 28, 1945). H. A. Zintel & Co. report streptomycin blood levels well maintained with slow urinary excretion, low toxicity, no side actions, wide tissue distribution, poor oral absorption (*Am. J. Med. Sci.*,

\* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacological Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

210:421, 1945). B. A. Johnson & Co. obtain "bacitracin" from *B. subtilis*, a water soluble, non-toxic, heat stable, effective agent vs. hemolytic streptococci and staphylococci (*Science*, 102:376, October 12, 1945).

4. *News*: G. R. Herrmann and P. A. Rockwell report on reversible and irreversible liver disease in reference to choline (*Texas St. J. Med.*, 41:288, 1945). D. E. Clark & Co. conclude that lipotropic effect of lipocaine is due to some factor other than choline, methionine or protein action (*Am. J. Physiol.*, 144:620, 1945). B. A. Houssay and J. Sara observe that thyroid enhances toxic and diabetogenic action of alloxan (*Rev. Soc. Argent. Biol.*, 21:81, 1945). E. de Robertis and W. W. Nowinski find proteolytic effect of pathological thyroid greater than normal (*Ibid.*, p. 120). A. Van Harreveld notes re-innervation of denervated fibers by adjacent functioning motor groups (*Am. J. Physiol.*, 144:477, 1945). A. E. Ritchie reviews physiology of peripheral nerve injury (*Edin. Med. Surg. J.*, 52:289, 1945). N. W. Shock and W. H. Sebrell observe increased work output (from frog muscle) after thiamine pyrophosphate (*Proc. Soc. Exp. Biol. Med.*, 59:212, 1945). R. Gubner and J. DiPalma say that glycine increases peripheral blood flow (*Ibid.*, 170). E. Gellhorn reports recovery of inhibited conditioned reflexes after shock therapy (*Ibid.*, 155). H. L. Hamilton surveys biochemorphology of p-aminobenzoic acid inhibition of rickettsial growth (*Ibid.*, 220). J. B. de C. M. Saunders and W. Haymaker compare sulfa drug toxicity on chick brain cultures (*Ibid.*, 306). Enjoyable is C. D. O'Malley and J. B. de C. M. Saunders note on *St. Apollonia* (*J. Am. Coll. Dent.*, 10:101, 1945). H. L. Segal propose anion exchange resin (polyamine formaldehyde) to control gastro-enteric pH (*GastroEnt.*, 4:484, 1945). W. H. Lewis and A. G. Richards find DDT non-toxic to cells in culture (*Science*, 102, 330, September 28, 1945).

#### Premarital and Prenatal Laws in Effect Five Years.

—Five years of operation of the California laws requiring premarital and prenatal tests for syphilis were completed in September. Total number of tests performed under both laws had nearly reached the two million mark by the end of September, 1945.

With the migration into the State during the war of a large number of people from states which have syphilis rates higher than the rate in California, the number of positive and doubtful premarital and prenatal tests has risen.

During the first nine months of 1945, 2.2 per cent of premarital tests and 2.3 per cent of prenatal tests were reported as positive or doubtful. The percentage of positive and doubtful tests during the five-year period is: premarital, 1.9 per cent; prenatal, 1.7 per cent.

From September, 1939, through August, 1945, 963,058 premarital tests were reported of which 724,408 were performed in private laboratories. During the same period, 942,143 prenatal tests were reported, of which 453,318 were performed in private laboratories.

**Plague Demonstrated in Wild Rodents in Seven California Counties.**—Plague has been demonstrated in wild rodents and their ectoparasites collected in seven counties by survey crews of the Bureau of Sanitary Inspections during the summer months.

The counties are: Alpine, Kern, Merced, Placer, San Benito, San Bernardino and Santa Clara. *C. bebbingi*, *C. becheyi* and golden mantled squirrels and their fleas, ticks and lice are involved in the findings.

During the first nine months of 1945 survey crews collected and examined 30,298 wild rodents. Over 310,000 fleas, 1,700 ticks and 6,800 lice were collected and sent to the State Laboratory for examination. All rodents

showing suspicious lesions also were examined in the laboratory.

Rat trapping operations were conducted in 67 cities and towns during the first nine months of the year in which 20,764 rats were collected and examined and 12,000 fleas were sent to the laboratory for examination. Up to October 1st, plague had not been demonstrated in any rats or their fleas.

**National Foundation for Infantile Paralysis Appropriations.**—In the year ending last May 31, the National Foundation allotted the unprecedented sum of \$4,157,814.15 for research, education and epidemic relief—exceeding authorizations for any previous year by more than \$2,000,000.

During the 12 months covered by the 1945 Annual Report, appropriations were as follows:

For public health groups, hospitals and universities, to train competent personnel and broaden public understanding of the polio problem, \$2,108,674.52;

For emergency epidemic aid, \$1,461,680.55;

For scientific research and investigation, \$304,444.36;

To universities, hospitals and the U. S. Public Health Service for the study of more precise methods of reporting clinical cases, \$406,427.09.

These appropriations do not include disbursements authorized in previous years for long range programs, some for as long as five years. During the period covered by this report, \$245,439.02 was distributed on such long-term grants.

**Neuropathologist for Langley Porter Clinic.**—Dr. Nathan Malamud has been appointed as neuropathologist at Langley Porter Clinic and associate clinical professor of psychiatry in the Medical School on the San Francisco campus of the University of California. In announcing the new staff member, Dr. Karl M. Bowman, director of the Clinic, says that while an excellent neuropathological laboratory was constructed when the clinic was built, this is the first appointment of a full time neuropathologist, and will further the plans to attack the problem of mental disease from every possible angle.

Neuropathological material will be received from all the State hospitals. Thus Langley Porter Clinic will not only be coordinated with the Medical School of the University but will be the focus for these studies for the State hospital system, thus enabling the Clinic to enlarge its services to the state.

**American Association for the Study of Goiter.**—The American Association for the Study of Goiter again offers the Van Meter Prize Award of three hundred dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in Chicago, Illinois, in April or May, 1946, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy sent to the corresponding Secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia not later than February 20, 1946. The Committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

**Architect Speaks to Public Health Group.**—Planning for Public Health was the topic of a discussion



before the annual meeting of the Northern California Public Health Association, by Michael Goodman, associate professor of architecture on the Berkeley campus of the University of California. Speaking at the evening session November 16, his talk was based on a collaborative investigation conducted by the department of architecture and the school of public health under the direction of Professor Goodman and Mrs. S. P. Lucia, associate professor of biometry. Drawings made by students of architecture were used to illustrate the lecture.

Joint speaker of the evening was Colonel Alexander Heron of the State Reconstruction and Reemployment Committee, who told about the State program of postwar building and public projects.

**Christian Science Practitioner Signatures to Sick Leave Forms.**—The *San Francisco Municipal Review*, November 16, states: "At the request of Commissioner Allan E. Charles the annual sick leave ordinance is being amended to permit the signature of a Christian Science practitioner on sick leave forms. Currently the Civil Service Commission recognizes only the signature of a Doctor of Medicine on the sick leave forms."

**Press Clippings.**—Some news items from the daily press on matters related to medical practice follow:

**President Truman's New Health Plan Before A.M.A.**  
*Acting Surgeon General of V. A. Protests Government Medical Control*

Chicago, Dec. 4.—(UP.)—American Medical Association delegates, representing more than 125,000 physicians, met today to answer President Truman's proposal of a national health program.

More than 40 resolutions, many of them voicing the medical profession's opposition to the President's request for universal sickness insurance and health care were scheduled for consideration.

Maj. Gen. Paul R. Hawley, acting surgeon general, of Veterans' Administration, told A.M.A. delegates last night that a "free and uncontrolled medicine will solve its own problems and doesn't need the Government to tell it how."

He made no direct reference to Mr. Truman's proposal but emphasized that he did not approve of Government interference in the medical field.

**"No Federal Control"**

"Although I've been in Government service for thirty years, I don't want to see the Government control medicine throughout the country," he said.

General Hawley, medical director of the Veterans' Administration, said the V.A. had done an unprecedented job in treating thousands of veterans with an inadequate number of doctors, but he added that private physicians would have to participate to make the veterans program successful.

General Hawley disclosed that a program would enable doctors to offer their services on a part-time basis in veterans' hospitals, receiving standard fees from the Veterans' Administration.

The incoming president, Dr. Roger I. Lee, Boston, who was inaugurated last night, stressed the need for "constant and continuing" study to determine what constitutes "adequate" medical care.

He said that "while there have been many clarion shouts that medical care in the United States is inadequate," these claims too often failed to include the individual's attitude toward treatment by physicians.—*San Francisco News*, December 4.

**A.M.A. Unanimously Opposes Truman's New Health Program\***

Chicago, Dec. 4.—(INS.)—The American Medical Association today unanimously disapproved President Truman's plan for Federal tax supported health insurance.

The A.M.A. House of Delegates indorsed a statement describing the Truman plan as "socialized medicine" that would put the physician and his patient under political control and make doctors "clock watchers and slaves of a system."

The delegates adopted that part of the President's plan

covered by the Hill-Burton bill, which provides for Federal aid for the construction of hospitals and health centers.

Also adopted was the point asking for the development of a national research foundation, as introduced in the Magnusen bill. The delegates, in approving that point, specified that the foundation should be headed by a board of scientists, rather than a presidentially appointed individual, as suggested in the Kilgore bill.

Points referred back to committee were on compensation for loss of earnings due to sickness, and the extension of maternal and child health services, which the Wagner-Murray-Dingell bill would make effective by increased grants through the children's bureau to various states.

A resolution of the California delegation that no employee of the A.M.A. be permitted to have any other source of income was defeated, and two other resolutions of that delegation were referred back to committee.—*San Francisco Examiner*, December 5.

**Hotel Del Monte Reported Sold As Naval Academy**

Washington, Nov. 13.—California's fashionable 1,500 room Hotel Del Monte near Monterey, one of the West's most famous luxury hotels, has been secretly taken under option by the Navy Department, according to information today in the hands of Representative Gordon L. McDonough.

The California Congressman said he has been informed Del Monte will be used as the site of a naval academy postgraduate school. . . .—*San Francisco Call-Bulletin*, November 13.

**Science Finds New Elements**

Chicago, Nov. 16.—(INS.)—Dr. Glenn T. Seaborg, University of California chemist, today announced the discovery of two new elements in addition to plutonium, used in atomic bomb manufacture.

The two elements, as yet unnamed, are numbers 95 and 96 on the periodic table of known elements. They possess properties that are of the "rare-earth-like" series which starts with element 89, actinium, Dr. Seaborg said.

The new elements were found as a result of bombarding uranium 238 and plutonium 239 with high energy helium elements of 40 million electron volts.

Dr. Seaborg was co-discoverer of the new elements and of neptunium 237, a more stable twin of neptunium, element 93. He also was co-discoverer of plutonium, in 1940.

He said that plutonium, which he isolated in a University of Chicago laboratory, has been found to exist in minute amounts in a natural state.—*San Francisco Examiner*, November 17.

**Atomic Bombs at Low Cost Predicted by Dr. Oppenheimer**

Philadelphia, Nov. 16.—(AP.)—Atomic bombs cheap enough so that tens of thousands of them may be dropped in the next war were predicted today by Dr. J. Robert Oppenheimer, the former University of California scientist who headed the making of atomic bombs at Los Alamos, N. M.

Doctor Oppenheimer (now on the faculty of the California Institute of Technology) spoke at the first postwar Atomic Energy Conference held jointly by the American Philosophical Society and the National Academy of Sciences.

"We have made a thing," said Doctor Oppenheimer, "that has altered abruptly and profoundly the nature of the world."

"The atomic bomb is a very ordinary thing in some ways but—in a world of atomic weapons wars will cease."

"Because it is known the project cost us two billion dollars, and we dropped just two bombs, it is easy to think they must be expensive. But for any serious undertaking in atomic armament—and without any elements of technical novelty whatever, just doing things that have already been done, that estimate of cost would be high by something like a factor of one thousand. Atomic weapons, even with what we know today, can be cheap."

He said that except for the protecting hills the second bomb at Nagasaki would have "taken out" ten square miles or a little more. Great steel girders of factories were twisted and wrecked, he declared, and some of these wrecked factories were miles apart.

New medical discoveries from the atomic bomb were reported by Dr. Robert S. Stone, University of California. They were made in studying the rays emitted by thirty common chemical elements which are transformed into substances like radium.

\* For editorial and other comment, see pp. 209-264, 298-304, and 309.

Beta rays, streams of electrons, were produced so powerful that a single overexposure of this radiation caused skin cancer in animals. These rays have long been known to cause cancer, but never in a single shot.

Some of the radioactive by-products, he said, if absorbed into the body, will cause sarcoma (cancer) of the bone. Plutonium, the new metal that makes bombs, is just as dangerous as radium if taken into the human body.—San Francisco *Examiner*, November 17.

#### Medics Urging Federal Support for Science Research Program

Washington.—(UP.)—Three medical scientists agreed today that the Federal Government should set up a science research foundation but urged that member scientists be free of unnecessary governmental restrictions.

One of the scientists, Dr. E. M. Macewon, dean of the Iowa University Medical college, told the joint Senate commerce and military affairs subcommittee that "the only defense against future wars will be scientific and industrial supremacy."

Dr. Macewon also told the committee, which is studying bills to create a national science foundation, that the Allies won the war "because time and the blunders of a paperhanger gave our scientists an opportunity to develop more accurate and destructive weapons. . . ."

"Next time we will have neither of these: science will strike when ready and perhaps without warning," he said. "A generation or less ago preparedness was expressed in an international armament race. Tomorrow it will be a race for scientific supremacy."

Dr. A. N. Richards, chairman of the committee on medical research of the Office of Scientific Research and Development, declared that "if we do not wish to go scientifically bankrupt," scientists must be allowed to abandon the regimentation necessary during war.

"We must see to it that our (scientific) investigators return to their more deliberate habit; that they cease to be bedeviled by such requirements as that of himnonthly reports to an authority in Washington."—Merced *Star*, October 23.

#### British Medical Plan Is Scored

London, Nov. 12.—(INS.)—The *Daily Sketch* said today a Labor government bill bringing British hospitals under state control and specifying the areas in which physicians may practice will be introduced in parliament.

The newspaper said the bill was prepared without prior consultation with hospitals, local authorities or members of the medical profession.

The proposal, which exempts certain medical specialists, would restrict a family's choice of physicians to those in the immediate area and forbid the buying and selling of medical practices.

"Feudalism at its worst never indulged in such tyrannical folly as this," the newspaper declared.—Modesto *Bee*, November 12.

#### Dr. A. J. J. Rourke Named to Hospital Group

Dr. Anthony J. J. Rourke, physician superintendent of Stanford University Hospitals, has been appointed a member of the Council of Administrative Practice, it was announced yesterday by the American Hospital Association.

At the same time the Association announced the appointment of William P. Butler, manager of San Jose Hospital, as chairman of the Council on Association Relations.—San Francisco *Examiner*, November 19.

#### Heart Disease Research Set

New York, Nov. 1.—The life insurance industry announced today establishment of a \$3,500,000 fund for a six-year medical research in the United States and Canada.

M. Albert Linton, chairman of the joint committee of the American Life Convention and the Life Insurance Association of America, said 143 insurance companies had pledged support of the program.

The first goal will be research into what was called the "No. 1 killer"—heart and arterial disease, causing roughly 30 per cent of all deaths annually.—San Francisco *News*, November 1.

#### Chiropractors and a Four Year Course

Sacramento, Nov. 20.—(AP.)—Directors of the California Chiropractic Association have adopted an educational requirement of a four-year course of study, Dr. Raymond L. Parker, chairman of the Association's legislative council, said today.—San Francisco *Chronicle*, November 21.

#### California Doctors Back Pre-Pay Plan

Chicago, Dec. 2.—The medical profession must take the lead in building up national health or "surrender the responsibility to those in whose hands we would not like to see it placed," Joseph H. Howard, Bridgeport, Conn., and Dr. Phillip K. Gilman, San Anselmo, President of the California Medical Association, told the first annual conference of presidents and other officers of State Medical Societies today.

Condemning President Truman's proposed system of health insurance, Dr. Gilman said, however, that, "after the President's statement there is no longer any room for doubt about the necessity or wisdom of providing prepayment systems for meeting medical care costs."

"We must do something about it," he declared. "Today we (the medical profession) are forced to do something—something aggressive."

Both doctors concurred that "a need exists for better provision for building the national health" but insisted the better way of accomplishing this was through voluntary systems with participants having free choice of doctors and services.

Dr. Howard suggested that "the development of voluntary medical care program and the experience under these various programs can be consolidated to offer the right answer to the compulsory medical care program as advocated by President Truman."

The conference adopted a resolution calling for statewide health programs based on free choice of doctors and urged formation of a Department of Public Health and Medical Welfare with cabinet rank.—San Francisco *News*, December 3.

#### "Don't Curb Doctors," Says Medical Chief

Chicago, Dec. 3.—(UP.)—Major General Paul R. Hawley, medical director of the Veterans' Administration and Acting Surgeon General, tonight denounced any type of Government control of medicine, asserting the medical field "doesn't need the Government to tell it how" to solve its problems.

Hawley told the House of Delegates of the American Medical Association, now in session here, that "free and uncontrolled medicine will solve its own problems."

Hawley, who recently threatened to quit as Acting Surgeon General unless Congress approves General Omar Bradley's plan for veterans' hospitals, made no direct reference in his address to President Truman's universal medical care program. But he stated strongly he did not approve of any Government interference in the medical field.

#### V. A.'s Problem

He said the Veterans' Administration has an unprecedented job of treating thousands of veterans with an inadequate number of doctors.

He said private physicians would have to participate on a part time basis in veterans' hospitals and in private practice, receiving standard fees from the Veterans' Administration.

Earlier Dr. Herman L. Kretschmer of Chicago, retiring president, said President Truman's proposed program, if enacted, would constitute the first step toward totalitarianism in this country.

"When will the Legislators, the do-gooders, and others learn that disease cannot be cured by the passage of laws?" he said. "The physicians of this country will never be regimented."

#### "Un-American"

Dr. Kretschmer also directed the attention of the delegates to difficulties which he said are being placed in the path of returning Army and Navy doctors seeking to resume practice and urged that they be eliminated.

"Most hospital privileges," he said, "are contingent on membership in county medical societies. In some places, returning medical officers have been placed on what amounts to probation for one or two years. This practically closes the doors of hospitals to them, and the practice is unwarranted, unfair and un-American."

A resolution urging that voluntary non-profit state-wide health plans be established at once, with "free choice of purveyors of health care," was adopted at the first annual conference of presidents and other officers of state medical societies, attended by delegates from 37 states.

Also advocated was establishment of a Secretary of Health and Medical Care in the Cabinet, to be selected from practicing physicians, to direct "every Federal bureau and office whose duties are related to health and medical welfare."—San Francisco *News*, December 3.



## MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, Esq.

San Francisco

### A Physician Has No Authority to Engage Another Physician For a Patient Which He is Attending in the Absence of Express Authority From the Patient

The Appellate Department of the Superior Court of Los Angeles County on November 13, 1945, in an action entitled *McManus vs. Eymil* rendered a decision involving the authority of an attendant physician to engage another physician as a consultant without express authority from his patient. The Court held that in the absence of such authority the consulting physician who was called in without express authority from the patient could not look to the patient for payment of his fee. The decision of the Court was as follows:

Dr. A admittedly was not engaged directly by defendant or defendant's daughter to take care of defendant's wife. He states that he visited the patient at the request of Dr. B, the attending physician, who had been employed by defendant.

The evidence was insufficient to show that Dr. B had express authority from either defendant or defendant's daughter to engage Dr. A as consulting physician. There is no showing that defendant had ever heard of Dr. A or knew of his services until he received a bill from him. There is no showing that defendant at any time ratified the employment of Dr. A or agreed to pay for his services.

In the absence of express authority, a physician employed to take care of a patient has no implied authority to engage another physician at his employer's expense without the latter's knowledge or consent. (*Lindsay v. Freda* (1923), 2 D.L.R. 1180; *Webb v. Porto Rican American Tobacco Co.* (1910), 16 Porto Rico 378, 388; *Bond v. Hurd* (1904), 31 Mont. 314, 78 P. 579, 582; *Johnson v. Roberts* (1925), 212 Ala. 535, 103 S. 563, 564; *Wagner v. West Penn. Power Co.* (1933), 110 Penn. Supp. 221, 168 Atl. 478, 480.) Of course, we are dealing with a case where it was not impossible to seek consent. (In this connection see *Richter's Estate* (1928), 11 Penn. D. & C. Rep. 485, 490.) There are no California cases on this point involving physicians, but in the analogous situation involving attorneys, the rule is well established that an attorney has no authority by virtue of his retainer to employ another attorney at the expense of his client without previous authority or assent of the client. (*Cormac v. Murphy* (1922), 58 Cal. App. 366, 369, and cases cited; *Johnson v. California I.M.T. Assn.* (1938), 24 Cal. App. 2d 322, 335, 340; see also 90 A.L.R. 265.)

No account stated was created between Dr. A and defendant by the fact that Dr. A sent bills to which defendant failed to object for several months. The creation of an account stated presupposes an existing debt between the parties. (*Bennett v. Potter* (1919), 180 Cal. 738, 745; *Wine Packing Corp. v. Voss* (1940), 37 Cal. App. 2d 528, 539.) As we have noted above, no such condition existed in this case.

The judgment is reversed and the cause is remanded for a new trial, appellant to recover his costs of appeal.

As noted in the opinion of the Court this is a decision of first impression in California although authorities to the same effect are cited in other jurisdictions. The result of the decision makes it apparent that in any case where an attending physician desires to call in a consultant the consultant should make arrangements for payment of his services with the attending physician or with the patient. If there is no express authority from the patient and employment by the patient of the consulting physician, he will not be permitted to collect a fee from the patient and will therefore have to look only to the attending physician for payment. It is therefore impera-

tive that definite arrangements be made in advance so that misunderstandings of the type involved in the above case will be avoided.

### Government Medical Care System Declared Failure in New Zealand

Wellington (N.Z.)—Dec. 1.—In six years of operation New Zealand's system of state medical care has ballooned costs, jammed hospitals, promoted a physicians' racket of large dimensions and speeded the development of a nation of nostrum takers. It has not cut sickness and has not provided adequate medical service.

What happens when a nation goes over to free medical care is shown by figures covering admittances to the national hospital system. In 1932 admissions were 79,000; in 1944, latest year for which statistics are available, they were 171,000. Undoubtedly today they are higher.

#### More Difficult to Get

Yet today, despite a major wartime increase of hospital beds, the New Zealander who needs hospital attention finds it harder to get because the administrative chiefs say their beds are jammed with the aged and chronically ill, senile and other long-term patients who ordinarily would have received care at home, but today are dispatched to hospitals by families eager to be quit of them.

Coincidentally hospitals lack accommodations for such vital cases as tuberculosis sufferers who are crowded out by these permanent dwellers. Silverstream Hospital, near here, earlier operated by the American Navy to treat men of our force in the Solomons and now taken over by Wellington Hospital in an effort to relieve pressure, already is well filled with these cases.

#### Cost Multiplies

The sharply rising costs of medical care are shown in the fact that the Socialist government originally budgeted on the basis of \$5,000,000 being sufficient annual payment for all physicians' services. Today the budget exceeds \$25,000,000. In part this is laid to overconsultation of physicians by anxious patients whose opportunity of nursing their neuroses has been enlarged by the free system. . . .—*Quentin Pope in Los Angeles Times*, December 2.

### Scientific Research—Some Comments

Although scientific researchers have existed since the days of ancient Greece, until the last three generations their numbers were so few and their activities so diverse that they were not often classified as members of the same profession. But with the organization of industrial research laboratories, having as their object the improvement of old, and the invention of new processes, products and machines, scientific research began to be regarded as a profession comparable to the profession of engineering, for example.

The field of industrial chemistry, notably in Germany, was perhaps the first in which professional researchers became relatively numerous. . . .

Herbert Hoover (in *The Times* of Sept. 19, 1940) said: "A thousand openings already beckon to action by applied science to use what we already know. Therefore the second step is more support to applied science research. We probably spend \$200,000,000 on that, mostly through government and industry. But that is only 15 per cent of our cigarette bill, and with the depression that has slackened, whereas it should be increased."

The first step of which he spoke was research in pure science as to which he said: "And at once I come to the first step in industrial efficiency. That is more support to research in pure science. In all of our universities and our scientific institutions I doubt if we are spending \$20,000,000 a year. That is about 7 per cent of our allowance for cosmetics." . . .—*Halbert P. Gillette in Los Angeles Times*, November 18.

### We've Had Enough Czars

The proposal in the House Banking Committee to create a Federal "czar" to solve the housing shortage is better calculated to tie more knots in the problem. We have tried out a few "czars" during the war; the experience does not make us want more of them. Leave the "czars" to baseball; there they are that industry's own business; the public does not have to go to baseball games unless it wants to.

The public is in dire need of more housing. It wants houses, not czars, and right away. *General experience with governmental control is that it slows everything up with snarls of red tape, even where the intentions are the best in the world.* . . .—Excerpts from an editorial in *San Francisco Chronicle*, December 4.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

## TWENTY-FIVE YEARS AGO†

### EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 12, December, 1920

EXCERPTS FROM EDITORIAL NOTES

*An Ancient Opinion on the Physician.*\*—"Honour\* a physician according to thy need of him with the honours due unto him; for verily the Lord hath created him. For from the Most High cometh healing; and from the kind he shall receive a gift. The skill of the physician shall lift up his head; and in the sight of great men he shall be admired. The Lord created medicines out of the earth; and a prudent man will have no disgust at them. Was not water made sweet with wood, that the virtue thereof might be known? And he gave men skill, that they might be glorified in his marvelous works. With them doth he heal a man, and taketh away his pain. With these will the apothecary make a confection; and his works shall not be brought to an end; and from him is peace upon the face of the earth.

"My son, in thy sickness be not negligent; but pray unto the Lord, and he shall heal thee. Put away wrong doing, and order thine hands aright, and cleanse thy heart from all manner of sin. Give a sweet savour, and a memorial of fine flour; and make fat thine offering, as one that is not. Then give place to the physician, for verily the Lord hath created him; and let him not go from thee, for thou hast need of him. There is a time when in their very hands is the issue for good. For they also shall beseech the Lord, that he may prosper them in giving relief and in healing for the maintenance of life."

*Cordial Congratulations, California!*—We congratulate the people of California on the high character of intelligence and fine discrimination which they exercised on Propositions 5, 6, 7 and 8 on November 2, 1920. These four propositions which were popularly known as the "Quack Quartet" were promoted by the allied hosts of quackery, but despite the vast sums of money that they spent, despite the orgy of lurid literature and advertising, despite their mendacious mouthpieces, despite all the misrepresentation and ballyhooing of their combined forces up and down the highways and byways of the state, the people of California defeated them decisively. . . .

*Reflections After the Battle.*—The lesson of the campaign is above all else, now that our sinews are tried, that we have won a notable and tremendous victory, that the struggle is but begun. Each election, each session of the Legislature for a generation to come, will doubtless see attacks on public health and scientific medicine staged by the same old foes of both. The lesson of the campaign is that organization is an absolute essential for success and that we must fight in the future as hard as in the past. We have not finished. We have barely begun. These foes of health and scientific medicine are always with us. They must be controlled. This control depends on two things: an enlightened public and an organized medical

(Continued in Front Advertising Section, on Page 16)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

\* From Ecclesiasticus XXXVIII. 1-14 verses.

## BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.

Secretary-Treasurer

### Board Proceedings

A regular meeting of the Board of Medical Examiners was held at 1020 N St., Sacramento, from October 15 to 18, 1945.

Written examinations were conducted and hearings were held on petitions for restoration of revoked certificates, as well as on revocation matters.

The following changes were made in the status of licentiates after regular hearings:

*Bernard Aronchik, M.D.* Certificate restored and he was placed on probation for a period of five years without narcotic privileges and with other specified terms;

*William Broken Carr, M.D.* Placed on probation for five years without alcoholic liquors and to report as specified in terms of probation;

*Howard Doane Mayers, M.D.* Certificate suspended for six months and placed on probation for additional five years without alcoholic liquors and to report as specified in terms of probation;

*Norman Claude Smith, D.S.C.* Placed on probation for five years without narcotic privileges and to report as specified in terms of probation.

### News

"Raymond L. V. Silvio, 52, of 1405 Fourth Street was fined \$500 today when he pleaded guilty to posing as a physician and selling 'medicines' brewed from fruit rinds and herbs to Sacramentans for as much as \$39 a bottle. He was charged with practicing medicine without a license after his arrest by Joseph W. Williams, special agent of the board of Medical Examiners. Municipal Judge James M. McDonnell ordered Silvio to serve six months in the county jail in event he cannot pay the fine. Williams claims Silvio during the last two months has victimized more than fifty west end residents, selling medicines he made himself in the kitchen of the hotel where he resides. The concoctions were put up in used wine bottles and coffee jars, usually of one quart size, and sold for prices ranging from \$26 to \$39 a bottle." (Sacramento Bee, Sept. 28, 1945.)

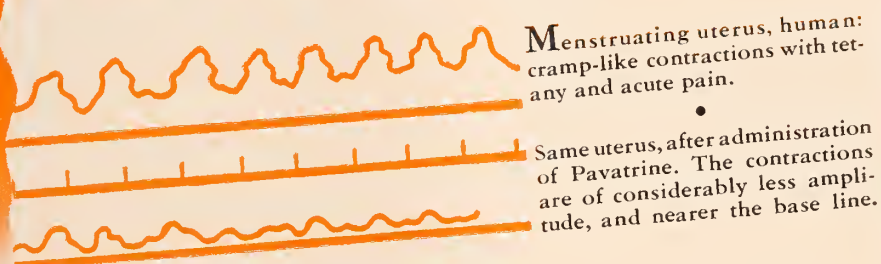
"On a self-imposed fast at Lincoln Heights Jail is Prof. Alfred Jacob Newman who plans to forego his victuals until—well until . . . Born Yacov Raphael Novachovitch, Prof. Newman, who says he has practiced in Los Angeles for 13 years, described himself as a chiropractor, osteopath, naturopath, hydrotherapist, electropathist and neuropathist. He's in jail under conviction on three counts of violating the Business and Professions Code and one count of violating the Health and Safety Code. He was sentenced to pay a \$250 fine or spend 50 days in jail on the first three counts, 90 days on the fourth count with the jail sentences to run concurrently. Drinking three or four quarts of water daily, so his stomach won't shrink, Prof. Newman reports that his weight is dropping about one pound a day. 'I'll continue to fast,' he vowed yesterday, 'until the judge allows my appeal or I am carried out of here on a stretcher.'" (Los Angeles Times, Oct. 8, 1945.)

(Continued from Front Advertising Section, Page 26)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.



# THE *CRAMPS* OF DYSMENORRHEA *brought under control*



Intrauterine balloon tracings reveal that Pavatrine has a morphine-like action in counteracting the tetanic contractions of essential dysmenorrhea. Symptomatic relief is afforded during the period of spasmolytic effect.

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(B-diethylaminoethyl fluorene-9-carboxylate-hydrochloride)

Indicated in:

- Dysmenorrhea due to hypertonicity or excessive contractions.
- Gastrointestinal Spasm—gastric, duodenal, sphincter of Oddi, colon.
- Urinary Bladder Spasm—in cystitis, instrumentation of tenesmus.

Average Dose: 1 or 2 tablets three times daily.

*Pavatrine is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois.*

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### PROCTOLOGY

### GASTRO-ENTEROLOGY and

### ALLIED SUBJECTS

For Information Address: MEDICAL EXECUTIVE OFFICE, 345 West 50th Street, New York, 19

### BOARD OF MEDICAL EXAMINERS

(Continued in Front Advertising Section, on Page 26)

when police raided her Fillmore Street clinic and discovered a safe containing \$300,000 in cash at her home, 274 Guerrero Street. . . . Early this month the Grand Jury refused to indict her on the current charge. Les Vogel, foreman, said evidence was insufficient. District Attorney Edmund G. Brown has announced he will press the conspiracy charge against the accused." (San Francisco Chronicle, Oct. 26, 1945.)

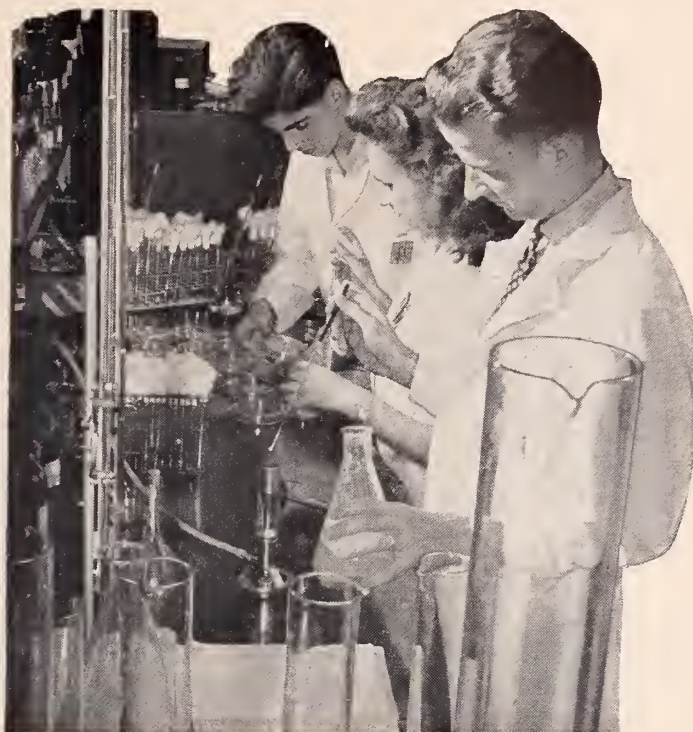
"'Guilty' to a charge of unlawfully prescribing and administering a narcotic, cocaine, for himself, was Dr. Rexford W. McBride's admission this morning to San Mateo Municipal Court Judge Francis W. Murphy, who sentenced the doctor a maximum penalty of 30 days in the

county jail or payment of a \$500 fine. Dr. McBride, prominent Burlingame physician, with offices at 205 Park Blvd., was charged July 27 with three violations of the State Narcotics Act in a complaint signed by Inspector Anthony J. Gazzoia of the state narcotics enforcement division. . . . It is possible that the division, with offices in San Francisco, will now launch a county wide investigation of the alleged misuse of narcotics. . . ." (Burlingame Advance, Sept. 19, 1945.)

"Dr. G. H. Penwell, 48, 911 Thirteenth Street, was arrested by state highway patrol officers on a charge of drunken driving late yesterday afternoon and placed in the county jail following a two car collision just south of the Tuolumne River bridge on the Crows Landing Road. Dr. Penwell was released from jail today after

(Continued on Page 32)





## PURE VITAMINS

*—products of Merck Research*

Merck research has been directly responsible for many important contributions to the synthesis, development, and large-scale production of individual vitamin factors in pure form.

In a number of instances, the pure vitamins may be considered to be products of Merck research. Several were originally synthesized in the Merck Research Laboratories, and others have been synthesized by Merck chemists and collaborators in associated laboratories.

Because most of the known vitamins have now been made available in pure form, effective therapy of specific vitamin deficiencies can be conducted on a rational and controlled basis, under the direction of the physician.

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(Vitamin B<sub>1</sub> Hydrochloride)

Riboflavin U.S.P.  
(Vitamin B<sub>2</sub>)

Niacin  
(Nicotinic Acid U.S.P.)

Niacinamide  
(Nicotinamide U.S.P.)

Pyridoxine Hydrochloride  
(Vitamin B<sub>6</sub> Hydrochloride)

Calcium Pantothenate Dextrorotatory  
Ascorbic Acid U.S.P.  
(Vitamin C)

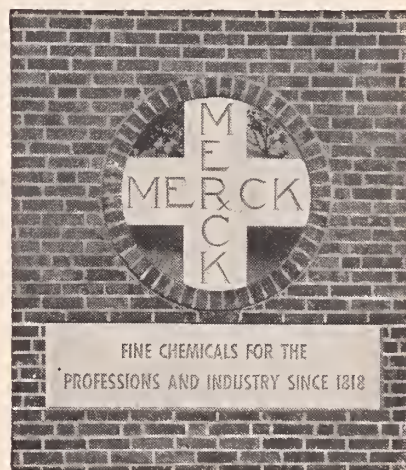
Vitamin K<sub>1</sub>  
(2-Methyl-3-Phytol-1,4-Naphthoquinone)

Menadione U.S.P.  
(2-Methyl-1,4-Naphthoquinone)  
(Vitamin K Active)

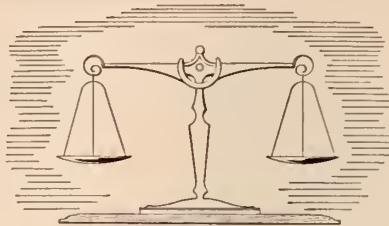
Alpha-Tocopherol  
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*Merck & Co., Inc. now manufactures all the vitamins commercially available in pure form, with the exception of vitamins A and D.*



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CALCIUM CARBONATE                      SODIUM PHOSPHATE  
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In correctly balanced proportion . . . continues to gain increasing favor with the medical profession as a prompt, safe neutralizing medium.

Widely used in all conditions of hyperacidity, genito-urinary infection, toxemia of pregnancy, pre- and postoperative treatment; also with excellent results during and following Sulfa and Penicillin therapy.



The Perfect Neutralizer

THE  
CALSO WATER CO.

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Address: STEPHEN SMITH, M.D., F.A.C.P.; CHARLES W. THOMPSON, M.D., F.A.C.P.

Medical Directors, Pasadena, California

### BOARD OF MEDICAL EXAMINERS

(Continued from Page 30)

posting \$250 bail. The highway patrol said Penwell's machine and a car operated by August Ernest Althoff, 313 Victoria Drive, were involved in the crash. No one was injured. Althoff signed a complaint against the doctor charging him with drunken driving." (Modesto Bee, Sept. 28, 1945.)

### More About DDT

An interview with Dr. Paul Muller of the J. R. Geigy Company, Switzerland, to whom the world owes a debt for the discovery of the insecticidal properties of DDT, and tall, suave Dr. Paul Lätiger, Director of Research there, brought forth some interesting information regarding DDT.

DDT, as everyone now knows, is a contact poison. What is not so well known is that the skin of insects contains a lipid layer, (a protective coating acting in some ways, like a raincoat) and DDT goes into solution in this layer. From there it attacks the nervous system of the insect. The skin of warm-blooded animals is entirely different, and since it does not include this lipid layer, DDT does not have the same or even a similar effect on man or other warm-blooded animals. True, a sufficient quantity of DDT swallowed or absorbed through the skin of a warm-blooded animal will cause trouble, but real danger is actually slight. Workers in plants where DDT powder is made are constantly sprinkled with the dust, with no untoward effects. When DDT is mixed with carriers that do not evaporate quickly, such as kerosene, and applied to the skin, contact is maintained for a long time and irritation may result. Birds can get enough

(Continued on Page 36)





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## *That Feeling of Well-Being*

Patients on "Premarin" therapy usually experience a general feeling of well-being in addition to relief of symptoms; this is confirmed by most of the many clinical reports. Rendering the patient symptom-free is, of course, the prime consideration of treatment; many physicians, however, feel that the restoration of a brighter mental outlook is also an important consideration when instituting therapy. "Premarin" will be found to exhibit the desirable characteristics of both the natural estrogens and the synthetic substances. Although highly potent, "Premarin" is derived exclusively from natural sources; it is

exceptionally well tolerated, and unpleasant side effects are seldom noted.

HIGHLY POTENT

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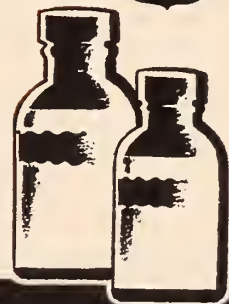
WELL TOLERATED

## *"Premarin"*

Reg. U. S. Pat. Off.

TABLETS

CONJUGATED  
ESTROGENS  
(equine)



Available in 2 potencies:

No. 866 (the YELLOW tablet), in bottles of 20, 100 and 1,000 tablets

No. 867 HALF-STRENGTH (the RED tablet), in bottles of 100 and 1,000 tablets



AYERST, McKENNA & HARRISON LTD.,  
22 E. 40th St., New York 16, N. Y.



*\*Ingraloids*  
**GLANTROPIN**

(Chorionic Gonadotropin)

In stable solution

One of the newer and more actively prescribed products of the Ingram Laboratories is Glantropin, a highly purified anterior pituitary-like hormone extracted from pregnancy urine under carefully controlled conditions and standardized biologically to International Units.

Glantropin, in sterile aqueous solution, is supplied in strengths of 100 International Units (Item No. 240), and 500 International Units (Item No. 241).

Professional samples of Glantropin will be gladly supplied on request.

\* Ingraloid is a trade name of the Ingram Laboratories to designate a brand of sterile solution of medicinals for parenteral administration.

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There are two units, The Colfax Hospital and the Bushnell Sanatorium, for the treatment of Pulmonary Tuberculosis.

The Colfax School for the Tuberculous is located in the pine clad Sierra Nevada foothills, at an elevation of 2,400 feet; an elevation free from the fogs of the valleys and free from extremes of heat or cold.

This Institution supplies, among other advantages:

1. Individual care and supervision under skilled physicians.
2. Education as to essentials of recovery from, and the prevention of the spread of, disease.
3. Complete laboratory and x-ray equipment.
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(Stanford Hospital),  
Consultant, Thoracic Surgery





**"you sure sound  
good to me, mister?"...**

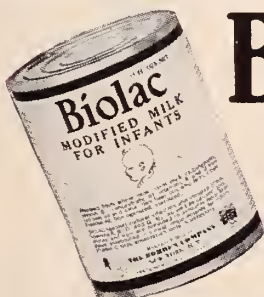
—A typical compliment to "Biolac Babies"—and, at the same time, a reflection of the physician's good judgment.

The soft-curd characteristics of Biolac assure ease of digestion. Adjusted milk fat content facilitates digestion and assimilation, with greater freedom from fat upsets; ample lactose assures soft, natural stool formation; and a high protein level contributes to optimal growth and health.

Since Biolac supplies adequate potencies of Vitamins A, B<sub>1</sub>, B<sub>2</sub>, and D, as well as iron, the need for time-consuming calculations of extra formula ingredients is eliminated. Indeed, Biolac (supplemented with vitamin C) provides *completely* for the nutritional requirements of the infant partially or entirely deprived of human milk.

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*Easily calculated...  
quickly prepared. 1 fl.  
oz. Biolac to 1½ fl. oz.  
water per pound of  
body weight.*



# Biolac

**"BABY TALK" FOR A GOOD SQUARE MEAL**

Biolac is a liquid modified milk, prepared from whole and skim milk, with added lactose, and fortified with vitamin B<sub>1</sub>, concentrate of vitamins A and D from cod liver oil, and iron. Evaporated, homogenized, and sterilized. Vitamin C supplementation only is necessary. Biolac is available in 13 fl. oz. cans at all drug stores.



**CASE HISTORY**

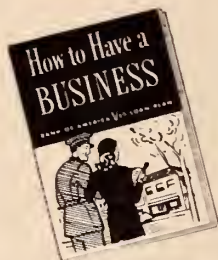
Record No. 151 Dr. John J. Doe  
 Name Richard F. Doe Address 123 Main Street  
 FINAL DIAGNOSIS Heart & Lungs FOLLOW UP RECORD Pain in region of  
 Date June 15, 1941 infection - improved  
 RESULT Recovered — Improved — Unimproved — Died Occupation Accountant  
 PERSONAL: Age 28 Sex Male M. W. D. None  
 FAMILY HISTORY: Negative

HABITS: Non  
smoker  
 PAST HEALTH: U.S.  
 PRESENT CONDITION: on his  
feet  
 PHYSICAL EXAMINATION: 7  
 TEMP. 9  
 HEAD: (in) For  
...

## CASE HISTORY OF THE "TIN CAN" DOCTOR

Lt. ——— went from med-school into Navy destroyer service. Wounded off Okinawa. Complete recovery; then honorable discharge. Eager to open office but needed financial aid. Learned that "G. I. Bill of Rights" guarantees certain loans up to 50% of loan or \$2,000 to qualified veterans. Checked, found Bank of America's complete lending service offered sound statewide credit. Under Bank of America's **Vet-loan Plan**, credit made available totaling \$4,800. At present, has established practice; repaying **Vet-loan** in convenient monthly payments.

Internes and medical students: If you are considering your own office, Bank of America invites you to drop in at any branch and talk over your plans. Whether or not you are a veteran, sound financing can be arranged through a **Timeplan** loan.



"How to Have a Business" and "Term Loans for Small Business" are two helpful Bank of America booklets which you might like to read. They are yours for the asking at any branch.



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This is 5% Alcohol and 5% Dextrose in Isotonic Solution of Sodium Chloride . . . a Baxter product frequently indicated in post-operative care.

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The itching of pruritis ani may often be relieved by dilation, especially when caused by a tight or spastic sphincter muscle which prevents bulky or dry stool from being expelled regularly and smoothly.

### YOUNG'S RECTAL DILATORS

have been found very effective in breaking the impulse of rectal muscle to keep itself locked. Sold only by prescription. Obtainable at your surgical supply house; available for patients at ethical drug stores. In sets of 4 graduated sizes, adult \$4.75, children's set \$4.50. Write for brochure.

F. E. YOUNG & COMPANY, 432 E. 75th St., Chicago 19, Illinois



### MORE ABOUT DDT

(Continued from Page 32)

DDT internally by eating poisoned insects to be harmed or even killed. Bees, being insects, are killed by contact with DDT.

The problem of the carrier is of primary importance. Molecules of DDT separated from each other have more chance to attack. The DDT molecule bristles with chlorine atoms, and these are the key to its action. The freer the chlorines are to reach the surface, the more efficiently they can work—effectiveness of DDT depends on its dispersal through a carrier. . . . Use of DDT in louse control was well publicized during the incipient typhus epidemic in Naples right after our troops landed

there in December, 1943. One of the results of this spectacular victory was that all cloth from which British army uniforms are cut is now first dipped in a DDT solution.—*Bulletin* of the Office of Pharmacal Information.

### Economic Issues Facing Hospitals

The future of American hospitals and some of the economic issues confronting the voluntary system receive careful consideration in the second book of the 1945 *Hospital Review* which substitutes for the annual convention of the American Hospital Association. This volume, discussing expansion of facilities, Blue Cross, the Commission on Hospital Care, hospitalization of veterans.

(Continued on Page 39)



# Foster mother

**S-M-A\*** replaces *breast feeding* whenever human milk is unavailable, of poor quality or insufficient quantity.

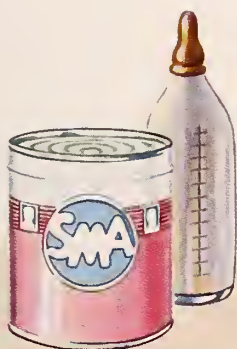
Special care has been taken to duplicate the protein, fat and carbohydrate content of human milk, both quantitatively and qualitatively. The successful nutritional history of S-M-A babies is due largely to its remarkable similarity to mother's milk.



S-M-A is derived from the milk of tuberculin-tested cows. Part of the butter fat of this milk is replaced with animal and vegetable fats, including biologically assayed cod liver oil. Milk sugar, vitamin A and D concentrate, carotene, thiamine hydrochloride, potassium chloride and iron are added.

\*REG. U. S. PAT. OFF.

*Supplied: 1 lb. tins with measuring cup.*





## SPECIAL DUTY FOODS FOR *Infant Feeding* PROBLEMS



### HIGH PROTEIN INTAKE NEEDED?

#### Use **PROTEIN S-M-A\*** (Acidulated)

A concentrated and readily digested high protein food, indicated particularly for premature and undernourished newborn infants, for malnutrition, in cases of diarrhea, and in any other condition where a high protein intake is required. (Powder—8 oz. tins.)



### HYP0-ALLERGENIC MILK MODIFICATION REQUIRED?

#### Use **ALERDEX\***

(Protein-free Maltose and Dextrose)

While Alerdex is useful in all milk formulas, this protein-free carbohydrate is especially indicated as a modifier in the hypo-allergenic milk diet of the infant sensitive to protein. Alerdex is prepared from noncereal starch by a process designed to eliminate every trace of protein. (Powder—16 oz. tins.)



### CAN'T TOLERATE COW'S MILK PROTEIN?

#### Use **HYP0-ALLERGIC\*** WHOLE MILK

Prolonged thermal processing modifies milk protein, minimizing its allergenic properties. When reconstituted with water, it is used in the same proportion as whole cow's milk. (Powder—1 lb. tins; liquid—14½ oz. tins.)

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will present a Certificate of Merit and a Five Hundred Dollar Award for the outstanding paper contributed on Research in Child Psychiatry, as selected by the Committee on Research of the American Psychiatric Association.

The Devereux Schools cordially invite all those interested in this field to participate and to submit papers by March 1. Papers will be returned to contestants.

The rules governing the Award may be secured from Mr. Austin M. Davies, Executive Assistant of the American Psychiatric Association, Room 924, 9 Rockefeller Plaza, New York 20, N. Y.

Presentation will be made at the Devereux Invitation Luncheon held during the meeting of the

## American Psychiatric Association

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## ECONOMIC ISSUES FACING HOSPITALS

(Continued from Page 38)

the care of the medically indigent, and other hospital problems, will be distributed to Association institutional members the first part of November.

Prefaced with an interpretation of the growing responsibilities of the voluntary hospital in the light of economic trends and public desires, the book treats in some detail fields in which hospitals may effect great advances for improved hospital service to their communities.

In a statement on Federal grants-in-aid for hospital surveys and construction, originally presented before a Congressional subcommittee considering the "Hospital Survey and Construction Act," the need for nation-wide planning of hospital facilities and for financial assistance

to regions with limited funds for health facilities is explained. Federal grants, to be administered by state governmental authorities under the general supervision of the surgeon general of the U. S. Public Health Service, would be used to inventory existing hospitals and health centers and determine the need for additional construction; to develop programs for the construction of hospitals and health centers which would afford adequate health facilities for all of the people; and to construct facilities in accordance with needs indicated by such surveys.

Some of the administrative difficulties encountered in the first studies and an indication of the final reports of the Commission on Hospital Care, nation-wide analysis of hospital needs as compared to hospital facilities, are presented by Dr. A. C. Bachmeyer, director of study.

(Continued on Page 40)

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\*In Military Service.

## ECONOMIC ISSUES FACING HOSPITALS

(Continued from Page 39)

Although the Commission has not yet formulated or suggested specific policies, it has come across a number of broad problems confronting American hospitals today. These Dr. Bachmeyer outlines in "Some Problems Confronting American Hospitals," the first preliminary paper to be issued on the important two-year study being conducted nationally under sponsorship of the American Hospital Association and a commission whose members represent every segment of American life.

Expansion of Blue Cross plans to secure increased benefits and coordination with physicians' plans are treated in "Blue Cross Plans and Hospital Management," by John R. Mannix, chairman of the Hospital Service Plan Commission and head of the Plan for Hospital Care in Chicago. Positive action programs of public health by the Plans, the enrollment of low-income groups, and unified programs in communities and states to include all hospitals are given consideration for the future.

"Hospital Care of the Medically Indigent," by Everett W. Jones, vice-president of the Modern Hospital Publishing Co., compares the various states' provisions for hospital reimbursement for care of the indigent. Preliminary measures by hospitals to facilitate the securing of adequate government payments are suggested—the accurate determination of total income and patient days of care for the indigent, cooperation among non-governmental hospitals in developing better administration for state, city and county hospitals, etc.

Treatment of short-term non-service-connected illnesses of war veterans in community hospitals is weighed in "Hospital Care for Veterans." Background experiences

(Continued on Page 44)



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## ECONOMIC ISSUES FACING HOSPITALS

(Continued from Page 40)

in voluntary hospital care of veterans at government expense and a discussion of proposed measures to insure adequate hospital care for ex-servicemen are presented by Arden Hardgrove, superintendent of Norton Memorial Infirmary in Louisville and member of the Association's Council on Government Relations.

The first of the three books comprising the 1945 *Hospital Review*—"The Individual Hospital"—has now been distributed to member hospitals. Separately printed articles—"Measuring the Community for a Hospital," "Organization of the Medical Staff and Governing Board," are available for purchase. The address of the American Hospital Association is 18 East Division Street, Chicago 10, Illinois.

### Good Health and Private Medicine

It's the American way to throw tradition overboard whenever necessary to meet consumer demand for a good product, or create new markets for a better. Now California's doctors propose to take full advantage of our National trait, and really "sell" better health on a prepaid basis to the people of this State.

The doctors, firmly convinced that the private practice of medicine is the American way to good health service for everyone, spearheaded the successful fight against compulsory health insurance at the last session of the Legislature. They were certain that State medicine, vigorously pushed by the C.I.O. and the Warren Administration, meant poorer, not better health care for Californians, and danger to continued progress in medical science. The doctors had their own answer to the need

for prepayment of health costs—voluntary health insurance.

More than six years ago the California Medical Association pioneered prepaid health protection through the California Physicians' Service, by which people can provide for sickness expense on a regular budget basis. The system has demonstrated that good medical service can be provided practically and economically without straggling patients or doctors in bureaucratic red tape.

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When doctors prescribe a selling job for themselves—that's news. And if the job means better health for more people on a sound basis—that's good news!—*Vista Press*, September 20.

### The Influence of Marital Separations on the Birth Rate

Separation of wives from their husbands by widowhood, divorce, or absence without dissolution of marital ties, results in reduction of the birth rate among these women by 6 or 7 per cent below that attained in unbroken families. This reduction in the birth rate by marital separations is greatest in our urban communities and least in the farm areas. Considered geographically, the West suffers most severely in this regard and the North the least. These findings are derived from 1940 census data, which show the number of children under 5 years

(Continued on Page 52)

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Vollmer, E.S.: Use of the Benzedrine Inhaler for Children, Arch. Otolaryng. 26:91.

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1. *Human Fertility*, 10:25, March, 1945.



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\*McCune, W. S., and Evans, J. M.: Intraventricular Penicillin in the Treatment of Staphylococcic Meningitis, J. A. M. A. 125:705 (July 8) 1944.

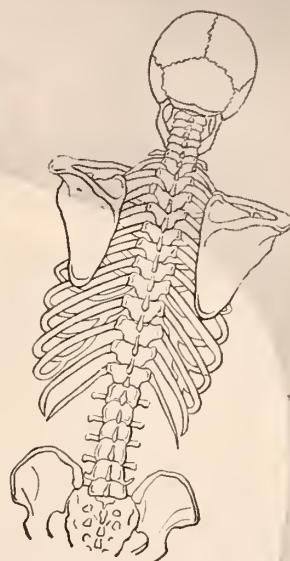
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MacNeal, W. J., and Pease, M. C.: Fulminant Meningococcemia Treated with

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Sweet, L. K.; Dumoff-Stanley, E.; Dowling, H. F., and Lepper, M. H.: The Treatment of Pneumococcic Meningitis with Penicillin, J. A. M. A. 127:263 (Feb. 3) 1945.



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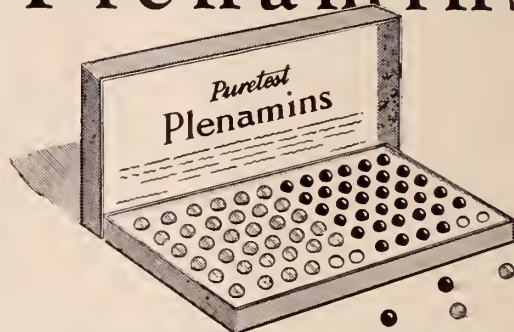
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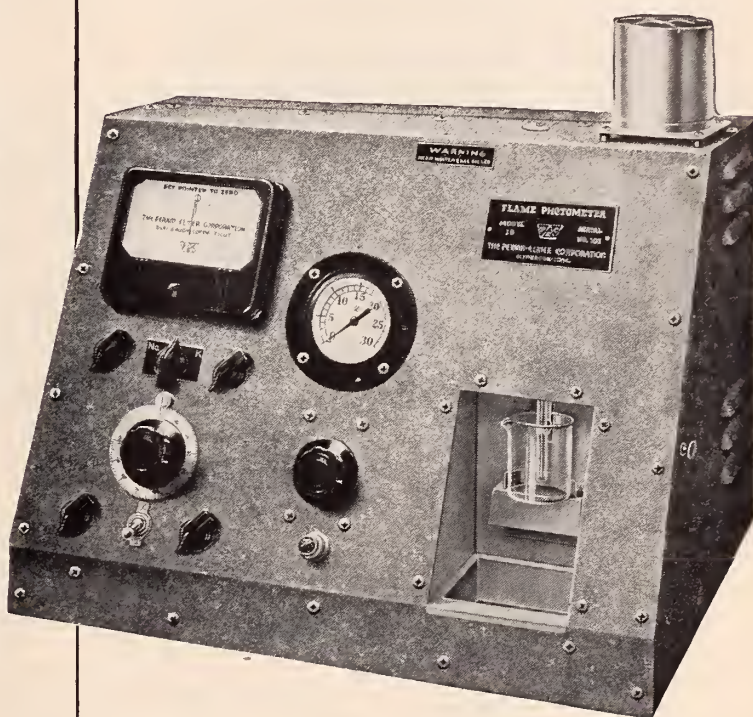
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### THE INFLUENCE OF MARITAL SEPARATIONS ON THE BIRTH RATE

(Continued from Page 44)

old per 1,000 native white women of ages 15 to 49 classified according to their marital status and place of residence.

Among white women of ages 15 to 49, whose first marriage had remained unbroken to the time of the 1940 census, there were 482 children under 5 years of age per 1,000 women. As compared with this, the ratio of children under 5 per 1,000 was 451 among all women in the same age group who had ever been married—that is, including the widowed, divorced, separated, and the remarried. The difference between these two ratios measures approximately the influence of marital separations in depressing the birth rate among native white women. The reduction naturally varies with the age of the

women. Among those under 25 years of age, the reduction is 4 per cent; it increases steadily with advance in age, rising to almost 13 per cent in the age group 40 to 44 years. This risk is, of course, a reflection of the increasing proportions of widowed, divorced, and separated women with advance in age.

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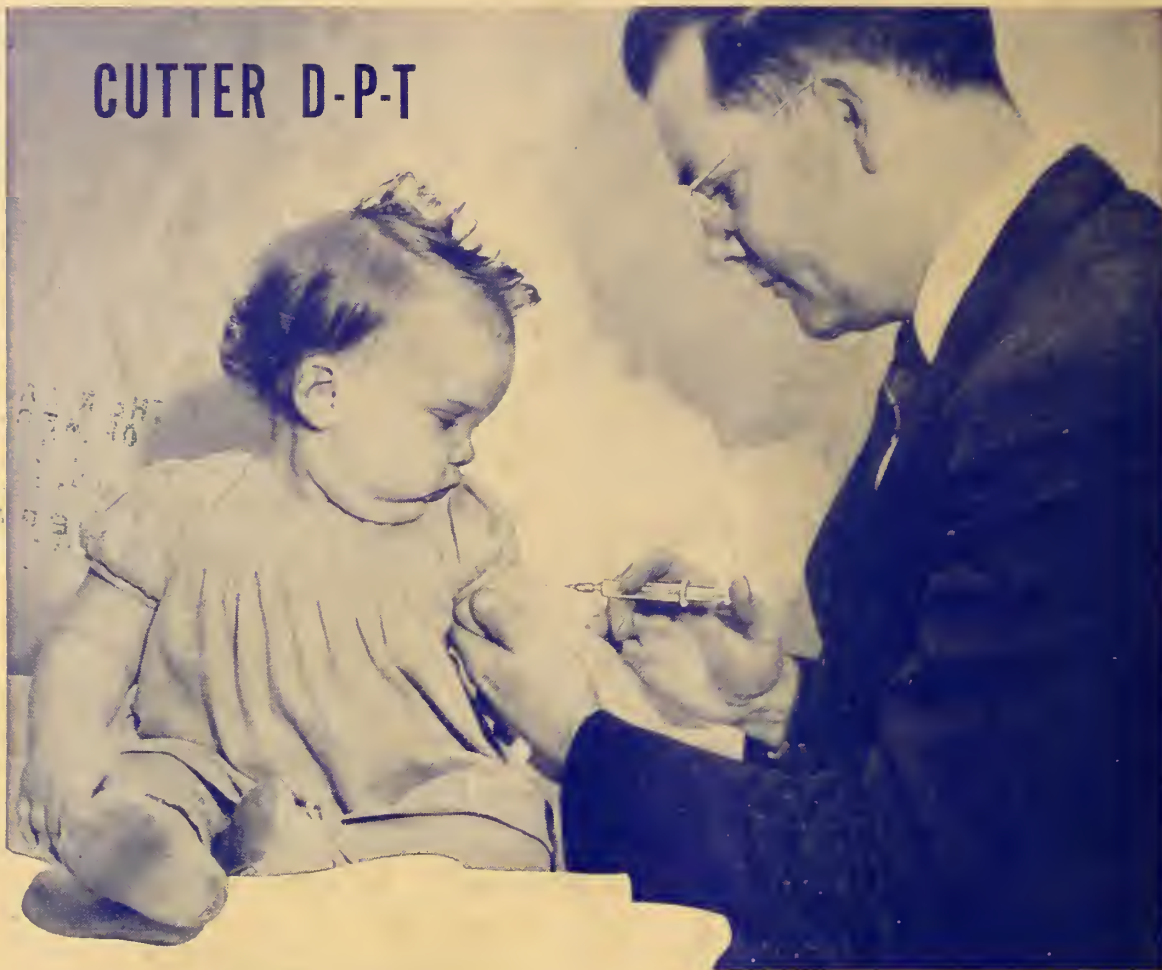
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**"Combined immunization against diphtheria, tetanus, and pertussis is safe, effective and easy" ★**

BUT—not all combined vaccines are alike! Cutter D-P-T, used in the series reported above, is unique in many ways.

Organisms for the Pertussis Vaccine used in "D-P-T" are grown on *human blood media*. Purified toxoids and extremely high pertussis count yield a vaccine so concentrated that *every cc. contains considerably more than a human dose* each of tetanus and diphtheria toxoids—plus 40 billion pertussis organisms in Phase I. Thus, your dosage schedule with "D-P-T" is only 0.5 cc., 1 cc., 1 cc.

Cutter D-P-T (Alhydrox) is aluminum hydroxide adsorbed, determined by Miller to be more potent than aluminum precipitated vaccines. Moreover, persistent nodules and sterile abscesses are eliminated almost entirely.

Again quoting Miller, "Lapin has emphasized the danger of producing sterile abscesses when pertussis vaccine is mixed with alum toxoids. We are not in a position

to comment . . . as aluminum hydroxide is the adsorbent used by us. In our group of 172 children who received 2 injections, no abscesses were noted."\*\*

In time and embarrassment saved you, in pain saved your patients, you'll find Cutter D-P-T has much to offer.

★

Hamilton, P. M., and Knouf, E. G.; J. of Ped., 25:238; Sept. 1944. \*\*Miller, J. J., and Saito, T. M.; J. of Ped., 21:31-44; July, 1942.

CUTTER LABORATORIES, BERKELEY, CALIF.

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